D3 Care Ltd

The Elms @ Kimblesworth

Inspection report

Elm Crescent
Kimblesworth
Chester Le Street
DH2 3QJ

Date of inspection visit:
17 July 2019
24 July 2019
30 July 2019

Date of publication:
06 September 2019

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Elms @ Kimblesworth is a care home which provides accommodation for people who require nursing and personal care. The service can provide care for up to 19 people. At the time of our inspection 14 people with mental health needs and learning disabilities were using the service. People with learning disabilities were therefore living in a home larger than current best practice guidance recommends.

The service has not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The principles and values ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
People's safety had been compromised. Three safeguarding concerns raised by professionals with the local authority had been investigated and substantiated. These concerns had included the safe use of medicines. Further concerns re the use of medicines were found during this inspection. People's personal risks required updating to include more person-centred information. Accidents and incidents had not been reviewed in a timely manner. The manager was continuing to learn lessons and had shared some lessons learnt with staff in a staff meeting.

The provider did not have a suitable system in place to measure people's dependency needs and enable them to decide how many staff should be on duty.

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 systems in the service did not support this practice.

Staff training and support were not effective. Staff were carrying out physical health checks on people without having had appropriate training.

Staff had worked with other professionals to support people's care needs. However, we found some opportunities had been missed where the involvement of other professionals may have benefitted people. Action had been taken when this had been pointed out to the manager.

Updated care plans required further improvement to enable staff to have sufficient information to meet people's care needs. The service did not have in place accessible information for people.

End of life care was provided in accordance with people's wishes. Where people had not wished to discuss

their end of life care, staff had documented this. Staff were respectful and kind towards people. They respected people's privacy and dignity. Their ability to provide appropriate care for people was reduced by not being suitably supported by the area manager and the provider.

Care in the home was not informed by national best practice guidance. There were three people who used the service with diagnosed learning disabilities. The service didn't apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support. People did not always have the appropriate support to give them choice and control. People's independence was not always promoted. We made a recommendation about this.

Governance arrangements in the service was poor. Audits carried out in the service did not identify the deficits we found. Arrangements to support the manager develop in their role were not in place.

People and staff were not fully engaged in the service. We made a recommendation about this.

Joint working with other professionals had been undermined in some circumstances where staff had not seen the opportunity to seek advice or share information.

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 requires improvement (published 9 April 2019). The provider completed an action plan after the last inspection to show what they would do and by when they would improve. At this inspection sufficient improvement had not been made and the provider was still in breach of regulations. The service had deteriorated to inadequate.

Why we inspected
The inspection was prompted in part by safeguarding concerns and a notification of a specific incident, following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident. The information CQC received about the incidents indicated concerns about the management of unsafe medicines practices and falls.

Enforcement
We have identified breaches in relation to people receiving inappropriate care to keep them safe, medicines, staff implementing the Mental Capacity Act, staff training and good governance at this inspection.

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

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

Follow up
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?

Requires Improvement

The service was not always 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.

The Elms @ Kimblesworth

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
Two inspectors carried out the inspection.

Service and service type
The Elms @ Kimblesworth 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.

The service did not have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The manager had applied to CQC to become registered and was awaiting the outcome of their registered manager's interview with our registration services.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We attended a local authority strategy meeting to review the findings of other professionals and hear about the work of the provider to improve the service. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with nine members of staff including the area manager, the manager, the deputy manager, an agency nurse, senior care workers, care workers and the cook.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality audits, policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data. We spoke with three professionals responsible for conducting safeguarding investigations to find out the outcome of their enquiries.

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

Using medicines safely; Assessing risk, safety monitoring and management

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

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

• Medicines were not always managed in a safe manner. The side effects of people's medicines were not documented. One person was receiving three medicines, each with similar side effects. The person's deteriorating presentation indicated the side effects of the three medicines were a possible cause of their symptoms. Staff could not explain why the person's dose of one medicine had increased. The agency nurse on duty confirmed they were in the process of seeking medical advice to establish if people's medicines were being correctly administered.
• Failure to safely administer medicines had resulted in changes to people's behaviour and subsequent safeguarding concerns had been raised. This had resulted in a person being asked to leave the home.
• Administration records for one person's medicines were inaccurate. We discussed this issue with the manager and the deputy manager who agreed there had been an error.
• People were prescribed topical medicines. Body maps to show staff where to apply topical medicines were not always in place. There were gaps in the in the topical medicine administration records.
• Assessing risk in the service was poor. Risk assessments were not personalised. This resulted in risks to people such as indicators of relapses in people's mental health were not documented.
• There was a failure to routinely review accidents and incidents. As a result, one person's falls had not been addressed in a timely manner.

We found people were placed at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Improvements had been made to checking the stock levels of medicines.

Systems and processes to safeguard people from the risk of abuse
• Systems and processes were not effective in safeguarding people.
• Staff had been trained in safeguarding people. However, due to the lack of understanding by staff of

people's complex needs, people had not been protected from harm. Consequently, people's health and wellbeing had deteriorated.
• Since our last inspection three serious safeguarding concerns had been raised by professionals with the local authority safeguarding team. These had been investigated and the concerns had been substantiated.

We found people were placed at risk of harm. This was a breach of regulation 13 (Safeguarding People from Improper Treatment or Abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The dependency tool used to assess people's needs to determine staffing levels failed to address the support people needed. Each person's support needs had not been aggregated to provide an indicative staffing level. Without an appropriate dependency tool, the provider was unable to demonstrate there were enough staff on duty.
• Concerns were raised regarding staffing levels. People required two to one support. During our inspection one staff member working alone needed to shout for help when a person threw a cup at them and injured their foot. We had received a notification about an assault on another staff member working alone in the corridor. Staff spoke with us about the provider's imminent plan to reduce the numbers of staff on duty to an unsafe level. During the inspection, assurances were given by the provider that the intended plan to reduce staffing levels had been cancelled.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staffing levels were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Safe recruitment processes were in place to ensure care staff were suitable to work in the service. However, the provider had failed to be sufficiently robust in appointing internally to management posts.

At our last inspection the provider had failed to carry out enough checks on agency staff employed in the service. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Improvements had been made to checks carried out on agency staff. The provider was no longer in breach of Regulation 19.

Preventing and controlling infection
• Cleaning was on-going throughout our inspection visits to reduce the risks of cross infection. The home was clean and tidy.

Learning lessons when things go wrong
• Throughout our inspection the manager demonstrated they were learning lessons about the safe running of a service. Lessons learnt had been shared with staff in a staff meeting.
• Appropriate new scales had been purchased to weigh people when one person who had lost a significant amount of weight was found to have been incorrectly weighed.

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 inadequate. At this inspection this key question remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• The service had not utilised national standards and guidance to inform the care practices in the home. For example, the service failed to demonstrate the principles and values which underpin CQC guidance Registering the Right Support. Guidance provided by the National Institute for Health and Care Excellence to support people with learning disabilities and mental health needs had also not been implemented.
• People's needs had been assessed prior to their admission to the home. However, the assessed care needs had not been transferred into care plans. This had resulted in a safeguarding concern being raised for one person.
• Risks to people's health and well-being caused by not always eating or drinking sufficient amounts were not well- managed. Staff had recently undertaken training on Focus on Under Nutrition, to assist their understanding on how to prevent malnutrition. Fortified drinks were provided to people. Kitchen staff had information about people's dietary requirements. They required further information to assist them understand how people's medicines affected their diet.
• Food and fluid charts were in place for four people. These were incomplete and did not show people received appropriate levels of nutrition and hydration. One person had lost a considerable amount of weight. Referrals had not been made to other professionals until the concerns had been raised by a professional visiting the service.

We found people were placed at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Improvements had been made in understanding people's food allergies. Work had been undertaken to understand the difference between people stating they were allergic to something when they did not like a particular food and their actual allergies.

• A new menu had been introduced which gave people a choice of meals. People confirmed they could choose from the menu.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to adhere to the principles of the Mental Capacity Act. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• The service continued not to adhere to the MCA and the subsequent code of practice. Insufficient work had been undertaken to adapt consent information to enable people with learning disabilities to make an informed decision. One person in their communication care plan was unable to read or write, however, they had signed consent documents. People's diagnosed mental health conditions was seen as prohibiting them having the capacity to make decisions. The approach taken by the services was discriminatory.
• Staff did not understand when a best interest decision was required. People had best interests' decisions in place when they had given their verbal consent and were able to understand the decision to be made.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate consent was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to support staff with appropriate training and supervision. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

• Insufficient staff support, supervision and training was provided to enable staff to effectively carry out their duties. Staff had not been trained to support people's diagnosed conditions. Following the last inspection, the area manager was planning to introduce training on psychosis. This had yet to be put in place.

• Staff were carrying out physical health checks on people without training or guidance. The documented health checks raised some concerns about people's health, yet no input had been requested from other healthcare professionals.

We found no evidence that people had been harmed however, training and staff support were not in place to ensure staff could meet people's care needs. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Staff had not always made contact with other agencies when people's needs had changed. There were instances where referrals to other professionals would have proved beneficial for people.
• Assessments carried out by people's care coordinators included details regarding people's physical and mental health needs. These were not always documented in people's care plans. For example, in one person's communication plan staff had documented the person had no visual impairments. In their assessment carried out by their care coordinator the person had significant visual challenges.
• Staff had liaised with community-based healthcare professionals about people's pre-existing conditions.

Adapting service, design, decoration to meet people's needs
• The home had been refurbished within the last year. People did not require any assistance in finding their way around the home.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection, this key question has remained the same. 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
• The manager and staff did their best to ensure people were well treated and supported. However, the care provided by them was significantly undermined by the failure of the provider and the area manager to ensure staff were well trained and supported to carry out their role. This lack of care to staff meant overall people were not always well treated.
• Staff spoke to people in kind tones, listened to responses and provided reassurances where necessary.
• Staff used humour to support people. People had trusting relationships with staff.
• Staff went to the local shop for people to purchase items they needed. One person told us staff always got their toffees.

Supporting people to express their views and be involved in making decisions about their care
• Forums such as resident's meetings were not held with any rigour to support a culture where people's views were routinely gathered and acted upon.
• Staff provided people with options throughout their day and respected their choices. However, the choices people were given were limited. For example, options to go out each day were not provided.

Respecting and promoting people's privacy, dignity and independence.
• Staff respected people's privacy and dignity. People, when required were assisted with their personal care behind closed doors. They told us they liked the staff and thought they were good.
• A kitchen had been refurbished where people could develop independence skills. This had yet to be used to optimise people's abilities. Further work was required to develop a culture where people could be more independent.

We recommend people's care is reviewed to consider how they could develop greater independence skills.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to 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

At our last inspection the provider had failed to ensure people received personalised care. People were at risk of receiving inappropriate care. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

• Care plans failed to demonstrate people received person centre care. Staff were rewriting care plans in line with the provider's action plan to develop more person-centred care. We reviewed care plans which had been updated and found some care plans contained more specific information about people. However, there were gaps in the information provided to staff to tell them how to care for people. For example, staff were not guided to understand people's mental health needs including relapse indicators, triggers or symptoms.
• Care plans for people diagnosed with learning disabilities failed to address how staff could support people's independence, their choices and control over their lives. One person described to us some issues they were experiencing. We raised this concern with staff who told the person was always like that. Staff without proper training, failed to see the significance of the person's comments.
• Staff had failed to respond to guidance provided by other professionals. For example, advice on one person's medicines had not been followed.
• There was not a culture in the home of staff supporting people to access activities relevant to them. People's activity preferences had been listed in a file. These had not been used to formulate an activity's plan to encourage and support people to access the community to avoid social isolation. Where people were independently able to go to church or the local shop their isolation was reduced. One person had a small patch of the garden where they grew vegetables. They showed us their garden and told us what they were growing. Staff documented they had spent time in the garden, although nothing was documented about how staff were to support the person.
• People were not assisted to have a structured day to support their well-being. They spent their time walking up and down the corridor, going for meals in the dining room or smoking at the rear of the property. Staff tried to engage people in ad hoc activities such as karaoke. One person told us they enjoyed karaoke very much. An activities coordinator was employed in the service. However, their time was partly working as

a care worker. Without a structure in place to support people's well-being, we found two people's mental health had deteriorated resulting in minor self-harm. Staff did not recognise that these self-inflicted injuries could be because of people spending significant amounts of time without a suitable stimulus.

We found people were placed at risk of harm. This was a continued breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were assisted to have contact with others who were important to them.

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 service was not meeting the accessible information standard. Information was not available in appropriate ways to support people's communication needs.

Improving care quality in response to complaints or concerns
• The provider had a complaints policy in place. Since the last inspection the manager had sought feedback from relatives and had addressed a concern as a complaint. They had written to the relative with a response and provided reassurance the incident would not be repeated.

End of life care and support
• Care plans showed discussions had taken place with people about their end of life preferences. Staff had respected people's wishes not to discuss this sensitive issue.
• During our inspection care was given to one person at the end of their life. Arrangements had been put in place for the person's wishes to be carried out. Staff were deployed to be with the person throughout the day to attend to their needs.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed to ensure the governance arrangements in the home were suitable. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• There was a reactive culture in the home which did not promote an open and person-centred approach. Managers and staff were responding to concerns from other professionals and CQC without having the knowledge and capacity to achieve a positive culture. The emphasis was on constantly putting things right. Support and guidance to the manager from the area manager and the provider were not apparent.
• Investigations carried out by the local safeguarding teams demonstrated outcomes for people whose needs had become increasingly complex were poor.
• People were not empowered to take responsibility for their daily lives.
• Systems in place to monitor the performance of the service had failed to find the deficits identified by CQC and other professionals who had raised safeguarding alerts.
• The manager said they had not carried out care file audits as they were in the process of updating files. Updated files required review to ensure information was accurate and up-to-date. Provider visits to the service showed they had failed to review the audits carried out in the service. There was no oversight of food and fluid charts and physical health care charts to ensure people received appropriate care.
• Accidents and incidents had not been audited since January 2019. During the inspection period, the area manager completed the audits and dated them as if they had been completed at the end of each month. By carrying out the audits retrospectively the area manager failed to address a pattern of accidents for one person.

We found people were placed at risk of harm. This was a continued breach of regulation 17 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff felt supported by the manager. They told us they like the way the manager did the duty rota and

appreciated the manager was working hard to put things right.

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 manager felt she worked well with other agencies when things went wrong and told us she was "Open and honest." They had provided accurate information to investigations carried out by safeguarding professionals.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People were not always given an opportunity to be engaged in influencing the service. A recent survey involving people who used the service had been carried out. The survey had not been adapted to meet people's personal characteristics, and therefore was dependent on staff asking people questions. Further surveys of relatives and other professionals had yet to be undertaken.
• Staff had been engaged in a staff survey to seek their views. Staff meetings were held infrequently to support and guide staff.
• Links had yet to be forged with the local community. Only people who could access the community independently had access to people and places outside of the home in the local area on a regular basis.
• The provider had in place an equality and diversity monitoring form for staff when they applied to the service.

We recommend further work is undertaken to involve people and staff both in the service and in their community.

Working in partnership with others; Continuous learning and improving care
• Staff failed to identify areas of people's care where working in partnership with other professionals would have enhanced people's health and well-being. Sharing information held in the service about one person would have prevented a person's medicines being reduced by a medical professional, and their health being adversely affected.
• When professionals identified referrals to other partner agencies were required, the manager had acted to improve people's care. The manager had downloaded guidance to help them learn more about improving care standards. This had yet to be used to enhance staff practices.
• Staff had supported reviews of everyone's care carried out by care managers. Professionals confirmed staff had done this.