Rushcliffe Care Limited

Highfield Court

Inspection report

Stafford Road
Uttoxeter
Staffordshire
ST14 8QA

Tel: 01889568057
Website: www.rushcliffecare.co.uk

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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
Highfield Court is a care home providing personal care to up to 59 people. The service provides support to people who have a learning disability and autistic people. Some people also have mental health needs. The accommodation is divided into 22 separate bungalows. Some people live alone, and others live in small groups. At the time of our inspection there were 39 people using the service.

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

People's experience of the service and what we found:
Right Support: People were not supported to receive their medicines in a safe way. People's risks were not managed in a safe way. Systems and processes in place to safeguard people from the risk of abuse were not effective. People were not protected from the risk of infection. The provider did not ensure there were enough staff available. The provider had failed to ensure appropriate decision-specific mental capacity assessments were carried out. The service did not ensure staff had the skills, knowledge, and experience to deliver effective care and support. People's needs were not always understood and supported. People were not always supported to develop and maintain relationships, follow their interests, or take part in activities that were relevant to them.

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.

Right Care: People's needs were not always assessed; care and support were not always delivered in line with current standards. The provider did not always support people to achieve effective outcomes. The provider did not always ensure the service worked effectively within and across organisations to deliver effective care, support, and treatment. People's individual needs were not always met by the adaptation, design, and decoration of the premises. People were not always supported to eat and drink to maintain a balanced diet, although people told us they liked the food. People were not always supported to express their views and involved in decisions about their care. People were not always well supported and treated with respect by staff. People were not always supported as individuals or in line with their needs and preferences. People's end of life care needs were not always assessed.

Right Culture: People were not always supported to express their views and involved in decisions about their care. People were supported by a service which was not safe. People were not routinely and consistently protected from risks and avoidable harm. While people were asked for feedback in resident meetings and

through surveys, the provider's response to feedback led to 1 person being excluded from communal activities. The registered manager understood when things went wrong it was their legal responsibility to be open and honest. However, we identified missed opportunities for learning by the provider and registered manager because quality checks were not always effective. People, and those important to them, could raise concerns and complaints.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 28 June 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by the CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of people's risks. This inspection examined those risks.

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

Enforcement
We have identified breaches in relation to managing people's risks and environmental risks, assessing people's mental capacity, safe recruitment of staff, delivering person centred care, and the governance of the care home.

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 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? 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**

Highfield Court

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of 3 inspectors including a medicines inspector. There was also a Specialist Advisor (SpA). A SpA is a person with specialist knowledge to support inspections. An Expert by Experience also supported the inspection. 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
Highfield Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Highfield Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the 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.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 13 people who lived at the home. We spoke with 9 members of staff including the registered manager, audit and compliance officer, 1 team leader, 4 care workers and 2 activity coordinators. We also spoke with 4 visiting health and social care professionals.

We reviewed 10 people's care plans, medicines records, accident and incident records and safeguarding records. We also reviewed records relating to training, 3 recruitment files, quality assurance and feedback and complaints. Following the site visits, we gained feedback from 1 health and social care professional. We also reviewed the training matrix, staff rotas and dependency tool sent to us by the registered manager.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed manage and administer medicines safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvement and the provider remained in breach of regulation 12.

Using medicines safely

- People were not supported to receive their medicines in a safe way.
- We observed one person, who required medication to be administered in liquid form, was given whole tablets which they regurgitated. This meant they were at risk of choking and the provider could not be assured the medication was effective.
- Care plans did not always contain accurate information about people's medicines. For example, where people were prescribed antipsychotic medication, information was not included about the risks and benefits of taking the medication and the risk to others.
- Staff involved in handling medicines had received training around medicines however did not always follow instructions in individual medication care plans.
- Medicine Administration Records (MAR) were completed. The provider carried out audits to ensure there were no mistakes however these did not always identify practice which put people at risk.

The provider had failed to manage and administer medicines safely. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People's risks were not managed in a safe way.
- Care plans for people at risk from diabetes did not include information about safe blood sugar ranges and staff did not contact health agencies when required. One member of staff told us, "Diabetes care plans need updating to include more information to guide staff." This meant people were at risk from serious medical incidents.
- Where people's behaviours, including verbal, physical and sexual, put other people at risk, care plans did not include risk assessments to guide staff on how to manage these risks. This meant people were at increased risk of experiencing harm.
- People were at risk of not being able to call for help in an emergency. One person told us, "Sometimes the cord pull does not work, when it does staff sometimes take a long time to come to us." The provider's environmental checks identified 2 faulty call bells. However, we identified other faulty call bells and fed this back to the registered manager who arranged for them to by checked by the maintenance team.

The provider failed to manage people's risks and environmental risks safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse and avoidable harm; Learning lessons when things go wrong

● Systems and processes in place to safeguard people from the risk of abuse were not effective.

● Although staff had had safeguarding training and were able to tell us how they would respond to incidents, where some people displayed distressed behaviours impacting on others, these were not always recorded and investigated. This meant the provider could not be assured they were responding to concerns appropriately.

● The registered manager told inspectors 1 person with high risk skin needs was able to reposition themselves independently and staff would cause them harm if they were to reposition them. We saw records indicating staff supported them to reposition regularly and on one occasion the person screamed when staff attempted to support them to reposition. This meant the person was put at risk of harm by staff delivering care which was not required.

●The provider did not always learn lessons when things had gone wrong.

● There were systems in place to identify when things went wrong however accidents and incidents were not always recorded, reviewed and measures were not always put in place, where required, to reduce or remove risk.

The provider failed to ensure effective systems and processes were in place to safeguard people from the risk of abuse. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were not protected from the risk of infection.

● Kitchen and bathroom areas were not always kept clean. We found food storage items and bathroom equipment had not been cleaned. We found 1 bathroom did not have soap or paper towels available for people to be able to wash and dry their hands. This meant people were at risk from spread of infection.

● We observed 1 staff member not following handwashing procedures before administering medication. This meant the provider could not be assured people were protected from the spread of infection.

● Kitchen fridge and freezer temperatures were recorded daily however there were several gaps. Where checks had been completed, we found regular recordings where the temperature had exceeded the legal limit and no action had been taken to address this. This meant the provider could not be assured people were protected from the risk of infection.

● We found refrigerated foods had exceeded their use-by dates and some opened foods had no used-by dates. This meant people were at risk of infection from eating unsafe foods.

The provider failed to ensure effective infection control procedures were in place to protect people from the risk of infection. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider did not operate safe recruitment processes. For example, where a staff member declared potential criminal convictions during the recruitment process, a risk assessment was not put in place. Staff recruitment files did not always include full employment histories or appropriate references. This meant the provider could not be assured they were employing suitable staff, which in turn put people at increased risk

of harm.

The provider failed to ensure safe recruitment processes were in place. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not ensure there were enough staff available.
● The provider used a dependency tool. This helps the provider calculate the number of staff required based on the needs of people living in the home. Although staff rotas were in line with the dependency tool, people and staff told us there were not enough staff to meet people's needs. This meant we could not be assured people were receiving the care and support they required at the right times.
● One person told us, "More day staff are needed. We would like to go out more, but we can't due to lack of day staff." Another person told us, "There are never enough staff around in the day." One staff member told us, "We don't have enough staff. People do in-house activities, but they could go out more if we had more staff. If we are short staffed, people don't get to go out." Another staff member told us, "There are not enough, we get pulled out of one bungalow to go in another."
● We saw one person was not able to do their preferred activity due to staff being unavailable.

Visiting in Care Homes
● People were able to receive visitors without restrictions in line with best practice guidance.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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

At our last inspection the provider had failed to ensure people's consent and decision making had been appropriately assessed and recorded. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvement and the provider remained 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 provider had failed to ensure appropriate decision-specific mental capacity assessments were carried out. For example, where the provider had concerns about people being able to make specific decisions about their health needs, they had failed to ensure mental capacity assessments had been done. This meant people were not being protected by the MCA.
- We found the provider had incorrectly applied for a DoLS for 1 person who was able to choose to leave the care home freely.

The provider had failed to ensure people's consent and decision making had been appropriately assessed and recorded. This was a continued breach of regulation 11 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 were not always assessed and care and support was not always delivered in line with current standards. People did not always achieve effective outcomes.
● Where people were presumed to have capacity to make unwise decisions about their health needs, care plans did not include sufficient information to guide staff how to support them.
● Care plans included conflicting information. For example, 1 person was assessed as requiring medication to be administered covertly. However, their medication care plan indicated that implied consent was given.
● One person was assessed as requiring a sensor mat at night and dedicated one to one support to manage seizures, however these were not included in their care plan. The care plan guidance lacked detail about how staff should manage their seizures.
● Staff told us they were not able to view people's entire care plans on handheld devices they use to update people's information. This meant people were at risk of not receiving care in line with their care plans.

The provider failed to unsure people received care in line with their needs and preferences. This was a breach of regulation 9 (Person-centred care) 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; Adapting service, design, decoration to meet people's needs
● The provider did not always ensure the service worked effectively within and across organisations to deliver effective care, support, and treatment.
● Where people had complex health conditions, the provider did not always make appropriate referrals to health agencies to ensure their needs were met. For example, one person who required specialist support for a health condition was referred to the incorrect organisation.
● Where people required annual health checks as part of their health conditions, records did not always indicate these took place.
● People's individual needs were not always met by the adaptation, design, and decoration of the premises.
● One person was not able to have a bath or a shower as there was no hoist rail above their bath and the shower chair was not in use. This meant they were not being supported in line with their needs and preferences.

The provider failed to unsure people received care in line with their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People lived in bungalows across the site and could access the activities hub and the bistro. An out-building was being adapted into a learning zone.
● We saw people had photos of their loved ones and personal possessions were displayed in people's rooms.

Staff support: induction, training, skills and experience
● The service did not ensure staff had the skills, knowledge, and experience to deliver effective care and support.
● 15 members of staff had not completed their refresher safety training which included de-escalation strategies for staff working with people who present with distressed behaviours.
● Staff had not received diabetes training. Staff we spoke with were not able to tell us symptoms of hypoglycaemia (low blood sugars) and hyperglycaemia (high blood sugars). This meant people were at risk

of not having their medical needs met when required.
● Communication training did not include how to communicate effectively with people who had specific communication needs including Makaton.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to eat and drink to maintain a balanced diet.
● Care plans did not always guide staff how to encourage people with specific dietary needs to make healthy food and drink choices. Despite this people were satisfied with the quality of food and drink which met their preferences.
● One person told us, "The food is good here. They have a food menu to choose from in the morning. If I did not like the food on offer, I would ask for an alternative. I can eat when I want to, and usually have my food in the bistro."

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- People were not always supported to express their views and involved in decisions about their care.
- One person with behavioural needs was prevented from accessing the community on their own or from eating in the bistro. Their care plan did not include information about why these decisions had been made or how they were involved in decisions about their care. This meant they were at risk of social exclusion.
- People told us there were not enough vehicles for them to go out in the community when they would like and no alternative arrangements were made. One person said, "Sometimes there are transport issues, and no vehicle is available, which stops me going out."

The provider failed to unsure people received care in line with their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
- People were not always well supported and treated with respect by staff.
- Although we observed staff communicating with people in a polite and caring manner, they did not always offer choice or explain what they were doing. For example, people were not asked where they would prefer to have their medication or told what medication they were being given.
- We observed 1 person who needed support to use the toilet was not offered to use their commode and staff instead changed their continence aids in their room.
- People told us staff treated them with respect and were kind. One person told us, "Staff always talk to us about our care, they always ask us if it's okay to have our medication. Another person told us, "Staff always ask for my consent before they support me with anything."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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

- People were not always supported as individuals or in line with their needs and preferences.
- Although care plans were written in a personalised way, people were not always able to participate in their preferred activities due to staff being unavailable.
- Where 1 person was assessed to require one to one sessions to support with their emotional wellbeing, there was no evidence this support was taking place.
- Another person who enjoyed walking inside and outside the grounds, trips out and spending time in the sensory room with staff was not able to take part in these activities as staff felt they could not leave other people living in the same bungalow on their own.

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

- People's needs were not always understood and supported.
- One person, who used their own version of Makaton, required support to use pictures to communicate their needs, there was no evidence of communication aids being available. The registered manager told us more work needed to be done to improve their communication. However, there was no plan in place.
- Although some people had spent time with staff to teach them their communication needs, staff had not had bespoke communication training for people with complex communication needs including Makaton. This meant people were not supported to communicate their needs and preferences, which put people at increased risk of not receiving care in the ways they wished.

The provider failed to unsure people received care in line with their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● People's end of life care needs were not always assessed.

● We saw 1 example of a person's end of life preferences included in their care plan. However, where some care plans indicated people or their families were not ready to discuss end of life care, it was not clear if these were being reviewed.

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 were not always supported to develop and maintain relationships, follow their interests, or take part in activities that were relevant to them.

● Although there was an activity hub on site and activity coordinators, people we spoke to wanted to do more activities in the community. Two people told us, "We like to do activities in our bungalow and go out to the activity centre sometimes. We would like to go out more but cannot remember when we were last asked to go out."

● Some people told us staff were very supportive with maintaining relationships with friends and family. One person told us, "I see my family and friends regularly. They visit me in the bungalow and sometimes take me out with them." Another person told us, "My family come and see me in the home whenever they want to, and staff always arrange this for me."

Improving care quality in response to complaints or concerns

● People, and those important to them, could raise concerns and complaints.

● There was a complaints policy available to people.

● People told us they felt confident to raise comments or concerns. One person told us, "If I needed to make a complaint, I would go to see the [registered] manager in their office, I have not made any complaints, but feel if I needed to it would be sorted out by the manager."

● We saw examples of responses to complaints which addressed complainants' concerns to their satisfaction.

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

At our last inspection the provider had failed to establish systems to effectively assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvement and the provider remained in breach of regulation 17.

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

- The provider had failed to make enough improvement to ensure people received good quality, safe and effective care. This was the sixth consecutive time the provider had been rated less than good, which meant people had been exposed to poor care for a significant period of time.
- The provider did not maintain adequate oversight of the recruitment of staff to the service to ensure suitable and sufficient checks were made to ensure they were fit and proper people to work with vulnerable adults.
- Care plan audits failed to identify the service was not following the principles of the Mental Capacity Act 2005.
- The provider did not maintain oversight of medication administration procedures to ensure people received their medication safely.
- The provider did not maintain oversight of safety checks and audits to ensure they were being carried out appropriately to identify safety concerns and that where faults or concerns had been identified, corrective action was taken.
- The provider did not maintain adequate oversight of environmental checks to ensure service users were protected from the risk of infection.

The provider had failed to establish systems to effectively assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not routinely and consistently protected from risks and avoidable harm. This was because the registered manager and provider did not have effective systems in place to monitor, manage and improve risks.
- Some staff members told us they were treated differently and expected to do more than others. They did

not feel able to complain as it might affect their employment.
● A draft audit completed by the compliance manager had identified areas for improvement in care plans, risk assessments and mental capacity assessments. However, this did not lead to care plans being updated to accurately reflect people's needs and risks.
● Improvements identified in monthly care plan audits were not always recorded as having been completed. This meant the provider could not be assured people's care plans were kept up to date.
● Although the dependency tool used by the registered manager identified people's needs, the provider failed to ensure there were enough staff available to meet those needs. For example, people were not able to participate in their preferred activities and staff were concerned there were not enough staff to meet people's risks.

The provider had failed to establish systems to effectively assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● While people were asked for feedback in resident meetings and through surveys, the provider's response to feedback led to 1 person being excluded from communal activities. This meant there was a risk to their emotional wellbeing.
● Staff meetings and supervisions were held regularly. Meetings provided opportunities for staff to feedback their views and suggestions. One staff member told us, "We talk about how to improve care and self-development in supervisions and in team meetings we discuss residents' needs."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care; Working in partnership with others
● The registered manager understood when things went wrong it was their legal responsibility to be open and honest. However, we identified missed opportunities for learning by the provider and registered manager because quality checks were not always effective.
● Staff worked with external professionals which included GPs, social workers, and community nurses. However, support was not requested for some complex health decisions.
● We saw examples of the provider using duty of candour when responding to concerns raised by relatives.
● The registered manager understood their role and responsibilities to ensure notifiable incidents were reported to the appropriate authorities if required.
● The provider ensured relatives were informed and kept updated when things went wrong.