Heathcotes Care Limited

Heathcotes (Oadby)

Inspection report

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Date of inspection visit:
17 June 2019
18 June 2019

Date of publication:
01 August 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Heathcotes (Oadby) is a residential care home providing personal care to eight people at the time of the inspection. The service specialises in supporting people who have learning disabilities, autism, Asperger's syndrome and challenging behaviour.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to eight people. Seven people lived in the main building and one person lived in a self-contained flat joined to the main building. This is larger than current best practice guidance. However, the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size. There were deliberately no identifying signs, intercom, cameras or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
There were not always enough care staff to safely meet people's assessed support needs. People did not always receive the 1:1 support that they required. This also limited the opportunities for people to go out and engage in activities in the local community.

People on specialised diets were not always supported to eat and drink safely or maintain a balanced diet. This placed them at increased risk of harm.

People were not receiving person centred support that was appropriate, and which met their needs and preferences. Some people required a clear structure to their day activities and this was not always provided by the care staff. Independent living skill activities were not effectively planned and co-ordinated.

People were not always supported to have maximum choice and control of their lives.
Care staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, not all conditions relating to authorised deprivation of liberty had been met for one of the people who lived at the care home.

The registered manager had a quality assurance system in place to monitor the safety and quality of the service. However, this was not being fully, or effectively, used to assess, monitor and improve the quality and safety of the service provided to people.
People, and their relatives, told us the registered manager was approachable but that complaints and concerns were not always dealt with formally and in line with the provider's complaints procedure.

Care staff had not all received the training necessary to meet people's individual needs.
The service didn't always 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.

People were supported to maintain links with their families. However, it was not always clear whether the arrangements in place for transport were in people's best interests. Following the inspection, the provider confirmed that people could choose to pay for access to the care home vehicle or could be supported to use public transport instead.

People told us that they felt safe living in the care home and that the care staff were kind. However there were occasions when one person's dignity was not always maintained by the way they were supported to dress.

People were supported to access community healthcare support, and had health action plans in place, although urgent healthcare advice had not always been sought by care staff when needed.

People's communication needs were understood, and accessible information was available in the care home.

People had personalised their bedrooms and the communal areas had a homely feel. The care home had a sensory room and an enclosed garden available for people to use. A self-contained flat was provided so the occupant could learn independent living skills.

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

Rating at last inspection
The last rating for this service was good (published 17 November 2017).

Why we inspected
The inspection was prompted in part due to concerns received about support for people who have special dietary needs. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the five key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.
Since the inspection took place the provider has taken action to increase the monitoring of people's diets and also the monitoring of staffing levels at the care home.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Heathcotes (Oadby)

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
The care home was inspected by one inspector.

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

Notice of inspection
The inspection visit on 17 June 2019 was unannounced. We returned on 18 June 2019 to complete the inspection. That second inspection visit was announced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work at the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with six members of staff including the regional manager, registered manager, team leaders, and care staff. We observed care staff interactions with people.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including 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 and quality assurance records. We spoke with seven relatives about their experience of the care provided. We obtained feedback from two professionals who have regular contact with the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● There were not always enough care staff to meet people's assessed support needs. We reviewed the care staff roster records covering a 6 week period and identified that, on 20 of those days, there were insufficient care staff to provide the support hours that were required by people.

●Individual 1:1 support was not always provided to those who needed it. A care staff told us, "People can't go out like they want to, that causes [challenging] behaviours and then we have a chain reaction of behaviours."

● A person, who required 1:1 support to keep safe, left the building unescorted when not being supported by a care staff. This placed them at an increased risk of potential harm.

● People, who needed to be closely supported to eat and drink safely, were at risk of choking when not supported. A care staff told us, "The [recent drink] incident should not have happened. The 1:1 [care staff] should have been there." The registered manager had since reminded care staff about the need to be vigilant when providing 1:1 support to people.

The provider failed to ensure there were sufficient numbers of care staff deployed to meet people's assessed care and support needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had an effective recruitment policy and procedures in place, and the necessary staff pre-employment checks had been carried out. This helps to ensure that care staff are safe to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse

● People felt safe living at Heathcotes (Oadby). A person told us, "People look after me Ok here. If I wasn't happy I would talk to my keyworker".

● The care home had a vehicle which people used to access activities in the community. The provider made a weekly service charge to people, equivalent to their weekly personal independence payment (mobility component), for access to that vehicle. However, a relative told us they paid for a taxi because the care home vehicle was unavailable. We raised this with registered manager who told us they would investigate whether a repayment to the relative was appropriate on that occasion.

● A social worker told us they had challenged the provider, about the transport service charge, because transport costs were included in the normal weekly fee rate paid by the local authority. The social worker told us some people could use public transport or taxis to activities, and the use of the care home vehicle was not always in their best interests. Following the inspection, the provider told us that people can opt out

of the transport service charge arrangement if they wish or if it is not in their best interest.
● All care staff had received safeguarding training, were aware of the safeguarding procedure, and how to use it. There were safeguarding adults' policies in place, which care staff had access to.
● The registered manager understood their responsibilities for keeping people safe, including reporting safeguarding issues to the relevant authorities. These arrangements ensured people were protected from the risk of abuse.

Assessing risk, safety monitoring and management
● People's individual risks had been assessed and reviewed regularly by the registered manager. Changes in support needs were discussed at staff handovers. However, there was no effective means of ensuring care staff had read and understood the care plans. This was brought to the registered manager's attention who told us they would introduce a 'read and sign' sheet into each care plan section.
● Care staff told us that they understood how they needed to support people, but that they did not always understand why support needed to be provided in certain ways. For example, not all staff understood the advice provided by the health care professional about why a person required a specialised diet.
● The legionella risk assessment stated shower heads needed to be descaled regularly to reduce the risk of a legionella infection. Descaling was not being done. This was brought to the registered manager's attention who told us they would ensure this was done.
● The provider had a fire risk assessment in place and effective systems to carry out regular fire safety checks.
● Care staff had received fire safety training and personal emergency evacuation plans were in place so people could be supported to exit the care home in an emergency.
● Routine health and safety checks had been carried out, which helped to ensure the care home environment was kept safe.

Using medicines safely
● Medicine systems were organised, and people received their medicines when they should and as prescribed by their GP. The provider followed safe protocols for the receipt, storage and administration of medicines.
● The controlled drugs record was not fully completed and stated an incorrect dosage for one medication. This was brought to the attention of the registered manager who immediately arranged for the controlled drug record to be corrected.
● One person's prescribed food supplements were out of stock at the care home. This was due to a prescribing error and the team leader had contacted the GP practice to try and resolve the issue. We reviewed the medication records covering a 26-day period and found the food supplement had not been available on 17 of those days. This meant the person had been without the food supplements, which were a required part of their specialised diet support, and that put them at increased risk of malnutrition.
● The registered manager was introducing clearer guidance, for care staff, about the 'as and when required' medication. This described what each medicine was for, how it should be given, and how often. The medication administration records confirmed how often they were given.
● Team leaders were trained in how to administer prescribed medications, when people required them. This was underpinned by the provider's medication policy to which care staff had access.
● Medication errors were reported and investigated appropriately, and any necessary action taken to ensure improvements and prevent recurrence.

Preventing and controlling infection
● People's rooms, bathrooms and communal areas were clean, which reduced the risk of infections spreading. A care staff told us each person's laundry was done separately.

● All care staff had received training in infection control procedures as part of their induction.
● The provider had an infection control policy and personal protective equipment, such as disposable gloves and aprons, were available and used to prevent the spread of infections.
● Care staff did cleaning tasks during the day, and night care staff completed further cleaning.

Learning lessons when things go wrong
● The registered manager and regional manager, reviewed incidents, analysed trends, and acted when needed. This helped to keep people safe.
● Lessons were learnt from incidents. For example, a recent discovery of dropped medication in a bedroom showed the need to observe people closely when giving medication. The registered manager had addressed this with the team leaders.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People were not supported to eat and drink safely. For example, there had been instances where a person, who required a specialised diet, had been given food which was not prepared in the way advised by a health care professional. This put the person at increased risk of choking.
- People were not supported to eat and drink enough to maintain a balanced diet. People on specialised diets were not provided with enough food that they were willing to eat. For example, a person often declined the specially prepared food that was offered. There was limited evidence that they were then supported to have appropriate alternative food that they did find appetising.
- Food intake records were not routinely reviewed. For example, a person had not eaten for over 24 hours. Diet records showed that the person had declined all the specially prepared food that had been offered throughout the day, but there was no evidence that any action had been taken to address that. This was brought to the registered manager's attention who immediately arranged for regular monitoring of the food intake records.
- A person had not consistently received dietary supplements, as had been prescribed by a health care professional. This was brought to the registered manager's attention who contacted the pharmacy and GP to re-establish supplies.
- A person's appointment with a dietician had been missed. This was brought to the registered manager's attention who arranged for an urgent appointment to be made and specialist advice about the person's low food consumption was then received.
- One person had lost a significant amount of weight over the last six months and, although still within the healthy weight range, the ongoing rate of weight loss was not being effectively monitored. The methods used to monitor people's weight were not effective and some people were at risk of becoming underweight. The registered manager told us they would implement effective arrangements for the monitoring and review of people's weight.

The provider failed to ensure the nutritional and hydration needs of service users were being met. This placed people at risk of harm. This was a breach of regulation 14 (Meeting nutritional and hydration needs) 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

- The registered manager created care plans which were updated as people's needs changed. However, a care worker told us, "Just reading the care plans isn't enough. I think that someone should teach you about the person initially. They just give you the book and say read. That is difficult for new staff."

● Some relatives told us they were involved in care plan reviews, others told us they were not. A relative told us, "I'm meant to be invited to take part in the care plan reviews, but things just seem to happen and then they tell me about it later."
● The care staff did not always provide person centred support and care in line with local and national guidance and best practice guidelines. For example, the support needs of people who are on the autistic spectrum were not fully understood by care staff. This was evidenced by a lack of structured activities being provided for people and not all care staff had received autism awareness training.
● Positive behavioural support plans were in place to guide care staff on how to support people experiencing distress or anxiety. The support plans also identified when prescribed sedative medication or physical restraints should be used.

Staff support: induction, training, skills and experience
● Care staff told us they did not always receive the training needed to meet people's needs. A care staff told us, "I need more training about the different disabilities. Training is hard to access. Like how to deal with autism and the specific disabilities here."
● A relative told us, "Staff are scared in case [person] has a seizure. They may have had training in epilepsy, but they are not confident in knowing what they would need to do. I would expect all the staff to know what to do if [person had a seizure]."
● A relative told us, "I'm not sure that they have all the training, or the full understanding about [person's] autism. Some of them understand [person] but I am not sure that they all do.
● The provider had a staff training plan to identify when care staff required training. This indicated that not all care staff were fully trained.
● New staff completed induction training, which included working alongside more experienced care staff.
● Care staff told us they have regular handover sessions and supervision meetings.

Supporting people to live healthier lives, access healthcare services and support;
Staff working with other agencies to provide consistent, effective, timely care
● Care staff did not always obtain healthcare advice when necessary. A social worker told us, "On more than one occasion, [person] has been given food outside of their specialised diet. On two occasions medical advice was not sought." This placed the person at increased risk of harm.
● A relative told us, "[Person] has had a catheter in for a year, because of a medical condition. The staff don't understand about the catheter really. Sometimes it leaks, and we have found [person] in a wet bed. It is heart-breaking." The registered manager told us the catheter care is overseen by an external health care agency but that care staff should understand the basics.
● The registered manager ensured people were supported to have annual health checks with their GP.
● People had health action plans in place which detailed their individual health support needs, as well as records of visits to specialist and community healthcare services.
● People went to community health services when they needed to. A person told us, "Staff make the appointment for me, and someone always comes along with me." Care staff supported people to have their healthcare needs met.

Adapting service, design, decoration to meet people's needs
● The care home was adapted to meet people's needs. For example, the provider had converted a conservatory into a sensory area for people to use, and we observed a person using it to relax and take part in activities. We also observed people making use of the enclosed garden which was used as a place for people to sit outside and enjoy fresh air and sunshine.
● The care home had a 'homely' feel in the communal areas. The bathrooms and toilets met the needs of the people living there. A self-contained flat was provided to support a person to learn independent living

skills.
● People had personalised their bedrooms and the registered manager had supported a person's decision to have no curtains in their own bedroom. Frosted glazing had been installed instead to maintain their privacy.
● No window blind was in place in the communal bathroom, which only had frosted glazing. This was brought to the registered manager's attention who told us they would arrange for window blinds to be installed.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the care home was working within the principles of the MCA, and whether any restrictions on people's liberty had been authorised. We found that it was.
● We checked whether any conditions on the DoLs authorisations were being met. We found they were not being met in respect of one person. It had been required that a referral for autism screening be carried out and that had not been done. This was brought to the registered manager's attention who told us they would make the referral for the assessment. This delay had prevented the person from receiving confirmation of whether they were on the autism spectrum and specialist guidance about their support needs.
● All care staff received training in relation to MCA and DoLs and worked within the principles of MCA. Appropriate referrals to the local authority DoLs team had been made.
● People had given their consent to receive care from the provider and, where it had been assessed that an individual did not have the capacity to give consent, there had been an appropriate best interest process carried out.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● A care staff told us, "We keep things confidential about service users. Close their doors when doing personal care and keep it dignified." However, people's privacy and dignity was not always maintained. We observed a person dressed in a way which meant a medical device they were wearing was visible. Although the person did not appear concerned the care staff did not attempt to provide the appropriate cover to maintain their dignity.
● People were not always supported to develop their independent living skills. A social worker told us, "I feel staff have [people's best interests] at heart. However, given the day to day strains of minimal staffing, and highly challenging [people to support], this can become difficult to maintain."
● A relative told us, "We are looking at whether [person] can move into independent living because we think that might be better for them. We will have to do that rather than try and change things where they are now, because that isn't easy to do.
● Each person had a personal development plan in place, which detailed their independence goals and the steps needed to achieve them. However, those had not been regularly used by care staff and there was no consistent support provided to enable people to achieve their specific goals.

The provider failed to ensure that people who use their service received person centred care and treatment that is appropriate, meets their needs and reflects their personal 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
● The care staff were kind towards people. A person told us, "Nice staff. [keyworker] is lovely. The staff have helped me, they can only do so much."
● We observed a person approach the registered manager and indicate they wanted their back to be rubbed. The registered manager gently carried out that sensory activity and it was clear the person was greatly relaxed by it. This demonstrated a caring approach to people.
● A relative told us, "[Person] has been there since it first opened. The staff adore [person] and she loves it there." Another relative told us, "The staff there are super. They are friendly, caring and interested. They are good people."
● Care staff welcomed visits to the care home. A relative told us, "Staff always make me feel very welcome whenever I visit, and I know I can visit at any time."
● Care staff receive training about the provider's values during their induction. This is supported by the

provider's equality and diversity policy to which all care staff have access.

Supporting people to express their views and be involved in making decisions about their care
● People were supported to indicate whether they consented to receive the support as detailed in their care plans.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- People did not always receive personalised care which met their needs. People's day activities lacked structure. People who are on the autistic spectrum often prefer structured timetables to be in place as a means of reducing their anxiety. We found that structured activities were not being consistently provided.
- A social worker told us the provider had been asked to provide a highly structured plan for a person's 1:1 support activity during the day. That had not happened.
- The provider had placed an activity planning board in the kitchen, but this was not being used effectively. We observed a person decide what they wanted to do using the activity board, but those activities did not then take place during the day.
- A relative told us, "They don't seem to pre-plan activities or stick to routines. It is supposed to be an autism specialist service but often things just happen in an ad-hoc way or nothing happens at all."
- Care workers did not always support people to make choices about how they spent their time. A care staff told us, "A service user without a 1:1 [care staff] can cause them to be disappointed because they don't get to do their activities, it just isn't fair on them really."

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 registered manager understood the Accessible Information Standard. We saw documents in care plans and on notice boards, which were in an easy-read format.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to maintain contact with their relatives. This helped to maintain important family relationships. However, a relative told us there were not always enough staff available, who were able to drive the care home vehicle, and that made it difficult for their relative to visit them.

Improving care quality in response to complaints or concerns

- Complaints and concerns were dealt with informally by the registered manager. However, they were not always dealt with in line with the provider's complaints policy. Complaints were not always recorded or formally responded to. When complaints were dealt with by the provider's head office, a copy of the formal outcome was not always available at the care home.

● A relative told us, "If we do have any concerns we just ring the manager and we meet to talk about it." Another relative told us, "I complained about a lack of structure for [person]. I didn't get a formal response. The manager spoke to me on the phone, but I didn't get a letter or email."
● A social worker told us the registered manager listens to concerns raised but this does not always lead to service improvements. For example, the need to increase the structure of day time activities for some people.
● A social worker told us they do not always get a timely response to concerns emailed to the provider. For example, relating to the transport service charge.

End of life care and support
● People had end of life plans within their general care plans, although no one was currently receiving end of life support.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager did not effectively support the care staff to provide person centred support which achieved good outcomes for people. Staff roster management meant there were days when insufficient care staff were available to meet people's assessed support needs. This meant people were not able to go out when they wanted or do social activities.
- Care staff told us, "Morale is quite low here. There are good days and bad days, but [care staff] are slightly unhappy most of the time."
- Care staff told us the registered manager was approachable and they felt supported by them.
- The registered manager, and all the staff we spoke with and observed, told us they were committed to providing person centred, high quality care. However, this was not always provided when staff numbers were low and this commitment to quality had not been converted into co-ordinated improvement action.
- The ratings from our previous inspection were displayed so that visitors could see and read our report.

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

- The registered manager carried out regular audits of care plans and risk assessments. However, this had not identified that a person had not eaten for over 24 hours and that prescribed food supplements had not been available for a significant number of days. It also did not identify that some people's care was not person centred or providing the care and treatment that was required as part of the commissioning agreement with the local authorities.
- The registered manager had a quality assurance system in place to monitor the safety and quality of the service and to review incidents. However, they were not being used to their full potential to improve the service provided to people.
- All care staff understood their roles within the care home. However, there was a lack of day to day co-ordination of their activities and this meant that the care provided was not always effective.
- The registered manager understood their responsibility for reporting deaths, incidents, injuries and other matters that affected people using the service. Notifying the CQC of these events is important so that we are kept informed and can check that appropriate action had been taken.

Working in partnership with others

- The registered manager and care staff worked in partnership with other professionals and agencies, such

as GPs, community health services. However, some health and social care professionals identified issues that had not been acted upon when raised with the management team.
● Relatives told us communication with them could be improved. A relative told us, "I used to get a weekly phone call with an update on how [person] had been that week, but that stopped. I discussed it with the manager who said it would be restarted, but that hasn't happened."

The systems and processes in place to assess, monitor and improve the quality and safety of the services provided were not fully or consistently effective. This was a breach of regulation 17 Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● The registered manager understood the importance of learning lessons, by reviewing incidents. However, this was not always effective. For example, there had been repeated incidents where people, who required special diets, had not been appropriately supported.

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 understood, and acted on, their duty of candour responsibility by contacting relatives after incidents involving family members occurred. This ensured relatives were notified of the incident and made aware of the causes and outcome.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, care staff and relatives, told us they could contribute their views on the service informally. Relatives had been sent an annual satisfaction survey which the registered manager reviewed and acted on.
● People's equality and diversity characteristics were identified during the initial assessment process and recorded in each person's care plan. This was available to guide care staff and was supported by the provider's equality and diversity policy.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that people who use their service received person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure the nutritional and hydration needs of service users were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes in place to assess, monitor and improve the quality and safety of the services provided were not fully or consistently effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet the assessed care needs of people.