

Rushcliffe Care Limited

# Jasmine Court Nursing Home

## Inspection report

Nottingham Road  
Loughborough  
Leicestershire  
LE11 1EU

Tel: 01509265141  
Website: [www.rushcliffecare.co.uk](http://www.rushcliffecare.co.uk)

Date of inspection visit:  
14 May 2019

Date of publication:  
17 June 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: Jasmine Court is a care home providing personal and nursing care and accommodation for up to 66 people, some of whom have dementia. Care is provided within six units over three floors. There were 56 people living at the service at the time of our inspection.

People's experience of using this service:

Appropriate numbers of staff had not been suitably deployed to meet people's needs in a safe or timely manner.

The risks associated with people's care and support had been assessed, though guidance within people's risk assessments and plans of care had not always been followed.

People were not always provided with their medicines in a timely manner. Medicine management was not always robust.

The providers safeguarding processes for the recording and reporting of unexplained bruising had not always been followed.

Systems in place to monitor the quality and safety of the service being provided were not always effective.

Best interest decisions were not always made by the appropriate people.

People were involved in making decisions about their care and support whenever possible and their consent was always obtained.

The staff team were aware of their responsibilities for keeping people safe from abuse and avoidable harm and had received training in the safeguarding of adults.

People told us they felt safe living at the service. They told us the staff team were kind and caring and they treated them in a considerate and respectful manner. Observations made during our visit showed people were not always treated in a dignified way.

People's needs had been assessed prior to them moving into the service and they had access to relevant healthcare services.

People's food and drink requirements had been assessed and records kept for people assessed as being at risk of not getting the food and drinks they needed to keep them well were up to date.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible. The policies and systems in the service supported this practice.

The necessary protective personal equipment was available, and the staff team had received training in infection control.

There were arrangements in place to make sure action was taken and lessons learned when things went wrong to improve the service provided.

Appropriate checks had been carried out on new members of staff to make sure they were suitable to work at the service, and training and support had been provided.

People were provided with a comfortable and homely place to live.

People were involved in how the service was run through meetings, the use of surveys and day to day conversations with the registered manager and the staff team.

The staff team had received training on end of life care to enable them to support people at the end of their life with dignity and compassion.

A formal complaints process was in place. People knew who to talk too should they have a concern about their care or support and the registered manager made sure complaints were handled appropriately.

Relatives and friends were encouraged to visit, and they told us the staff team made them welcome at all times.

The registered manager and management team worked in partnership with other agencies, so people received care and support that was consistent with their assessed needs.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered provider to take at the back of the full version of the report.

More information is in the detailed findings below.

Rating at last inspection: Good (report published 13 December 2016) all the key questions were rated Good except for safe which was rated requires improvement, and the service was rated as Good overall.

Rating at this inspection: We found evidence to demonstrate and support the overall rating of Requires Improvement.

Why we inspected: This was a planned inspection based on the previous rating.

Follow up: Going forward we will continue to monitor this service and plan to inspect in line with our re-inspection schedule for those services rated Requires Improvement.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

## 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 always safe

Details are in our Responsive findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective

Details are in our Responsive findings below.

**Requires Improvement** ●

### Is the service caring?

The service was not always caring

Details are in our Responsive 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 always well-led

Details are in our Well-Led findings below.

**Requires Improvement** ●

# Jasmine Court Nursing Home

## **Detailed findings**

### Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection was carried out by one inspector, an assistant inspector, a registered nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people living with dementia.

Service and service type: Jasmine Court is a 'care home'. People in care homes receive accommodation and nursing or personal care. 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 was unannounced.

What we did:

Before inspection: The provider had completed a Provider Information Return (PIR), this is information the provider is required to send us at least annually that provides key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service such as notifications. These are events which happened in the service that the provider is required to tell us about. We sought feedback from the local authority and clinical commissioning group who monitor the care and support people received and Healthwatch Leicestershire, the local consumer

champion for people using adult social care services. We used all this information to plan our inspection.

During inspection: We spoke with six people living there and nine visitors. We also spoke with the registered manager, three members of the senior management team, two registered nurses, a care team leader and twelve members of the staff team. We observed support being provided in the communal areas of the service. We reviewed a range of records about people's care and how the service was managed. This included seven people's care records. We also looked at associated documents including risk assessments and a sample of medicine records. We looked at records of meetings, both for the staff team and the people using the service and their relatives, staff training records and the recruitment checks carried out for a new staff member employed at the service. We also looked at a sample of the providers quality assurance audits the management team had completed.

After inspection: The registered manager provided us with copies of documents requested to demonstrate compliance with the regulations.

# Is the service safe?

## Our findings

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

Requires Improvement: 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. Regulations have not have been met.

### Staffing and recruitment

- Staffing numbers were not sufficient to meet the needs of the people using the service. This was particularly evident on the top floor of the service where there were four support workers and a registered nurse deployed to support 22 people. As well as having to assist people with their personal care they were also required to support people with behaviours that challenged others, which the staff team struggled with. One staff member explained, "The staffing levels are too low, this has been raised on numerous occasions, but management have advised that staffing won't be increased."
- Staffing levels within the service meant people were not always supported in a timely manner. People were still being assisted up late into the morning impacting on the time they had their breakfast, one staff member explained, "Some residents stay in bed for far too long. Sometimes we don't get them up until after 11.00am and then they have breakfast so don't want their lunch. Sometimes the night staff get residents up and give them breakfast, but you can't force them if they don't want to get up."
- Lunchtime on the top floor was unsafe. Several people were pacing around the room pulling at table cloths and touching each other. People were getting agitated and restless. At one point one person grabbed a hot drink from the drinks trolley. A staff member called to other staff for help as the person tried to physically assault them. There were not enough staff around to support people safely.
- Observations identified times when there were no staff members available in the lounges and limited interactions between the people using the service and the staff team was seen.
- A staff member explained, "We're rushing everything, sometimes you feel like you want to ring in sick. We get pains in our backs because we're short staffed, there's a lot of moving and handling."
- One person's records stated they needed two staff members to support them with their personal care due to challenging behaviour however, staff were not recording as to whether there were two staff present at these times.
- Staff felt they could not always respond to people's needs quickly because of staffing levels. Staff told us they felt anxious when leaving people to get food and drink from the kitchen or to go to the toilet in case it led to an incident occurring in their absence.
- Minutes of staff meetings held in March and April of this year acknowledged issues regarding staffing. An entry in both sets of minutes stated, 'We acknowledge sickness and absence is having an impact on staffing'. There was no evidence action had been taken to address these issues.
- Whilst staffing levels were monitored weekly, this had not identified the issues found at this inspection. On the day of our visit there was a distinct lack of staff presence throughout the service, throughout the day.

Appropriate numbers of staff had not been suitably deployed to meet people's needs in a safe or timely manner. These matters constituted a breach of Regulation 18, of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. Staffing.

- Recruitment processes remained robust.

Assessing risk, safety monitoring and management

- The risks associated with people's care and support had been assessed when they had first moved to the service. Risks assessed included those associated with the moving and handling of people, the risk of falls and the risks associated with people's behaviours.
- We did note one person had been assessed as requiring one to one support for most of the day and required hourly checks to be carried out. When not on one to one hours, support workers were required to check on them every 30 minutes to ensure they remained safe. Records held showed these were not being carried out as required.
- For two people who had recently lost weight there was no Malnutrition Universal Screening Tool in place. This is a tool used to identify adults at risk of malnutrition. Both people needed to be weighed every two weeks, however, on the day of our inspection it was identified they had not been weighed for three weeks.
- Whilst moving and handling equipment was in place, the staff team did not always use this to reduce the need for physically moving and handling people. For example, one person was lying flat on a profile bed (A special bed with an electric raiser) and wanted to get up. A staff member held the persons hands firmly and pulled them up to a sitting position rather than using the bed, which would have reduced the risk of injury to both the person using the service and the staff member.

People were placed at risk because risk assessments were not followed. These matters constituted a breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

- Checks had been carried out on the environment and on the equipment used. Personal emergency evacuation plans were in place and these showed how everyone must be assisted in the event of an emergency.

Systems and processes to safeguard people from the risk of abuse

- Whilst speaking with a family member they brought our attention to a large bruise on their relatives' hand. When we asked one of the registered nurses and looked at the person's records, there was no record of when or how this had occurred or that it had been reported to the nurse in charge.
- We found two other examples of bruising to people not being recorded, analysed or investigated.

There was a failure to record or report potential abuse. These matters constituted a breach of Regulation 13, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

- People felt safe living at the service and the staff team had received training on the safeguarding of adults. One person told us, "I feel very safe here, some days they can seem short staffed. They help me move from my bed to the wheelchair."
- When we asked a staff member what they would do if they felt someone was being abused they told us, "I would be a whistle blower. I would inform them [management team] immediately." Another explained, "I would report it to the manager or senior, they would definitely act."

Using medicines safely

- We observed medicines rounds took several hours to complete. This meant staff had to adjust the time people were given certain medicines, to ensure they were being taken as they should.



- We found a large stock of medicines waiting to be returned to the pharmacist. We were told this had been in the medicines room for some time but had yet to be recorded in the returns book. This meant there was a risk these medicines could be mislaid. We also found out of date influenza vaccines stored in the medicine fridge.
- A large container used to destroy spent tablets had a label stating, 'Do not pour liquids into container'. This clearly had liquids within it. Tubes of cream, a medicine pot and an insulin pen had also been incorrectly disposed of within the container. The top of the container was dirty and stained with powder and residue.
- Medicine records contained a photograph of the person to aid identification. Records were completed to show medicines were administered regularly.
- Staff members had received training in medicine management and their competency was regularly checked.
- We saw the registered nurse and care team leader allocated to administer medicines, did so consistently and methodically.

#### Preventing and controlling infection

- The staff team had received training on the prevention and control of infection and they followed the providers infection control policy. We saw personal protective equipment (PPE) such as gloves and aprons were readily available, and these were appropriately used throughout our visit.
- The service had a five-star food hygiene rating from the local authority. Five is the highest rating awarded by the Food Standards Agency (FSA). This showed the service demonstrated good food hygiene standards.
- We did note cleaning rotas were not always completed. This meant we could not be sure that fly screens, fridges, fryers and the dishwasher had been cleaned as often as it should have. The head cook felt it was a recording issue and told us they would raise this with the kitchen staff during supervision.

#### Learning lessons when things go wrong

- Lessons were learned, and improvements were made when things went wrong. This included making improvements to the mental capacity assessments completed to ensure the staff team were working in line with current legislation.

# 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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Some regulations may or may not have been met.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- Mental capacity assessment forms were not always complete and did not list all the possible illnesses which could impact on the person's ability to make a decision. These included for one person a stroke and an acquired brain injury.
- We did note Improvements were being made to the MCA documentation and process to ensure the staff team were working in line with current legislation.

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

- Nutritional risk assessments and plans of care had been developed for people's eating and drinking requirements. When people were at risk of losing weight, or required assistance from staff, records were kept of the amount they ate and drank.
- People's mealtime experience varied. Whilst people were supported in a relaxed manner on the middle floor, people on the top floor had a different experience. People using the service were pacing around and distracting each other. One person became aggressive and there were no staff around to support the staff member dealing with the situation. A staff member told us, "I need eyes in the back of my head."
- We observed staff supporting people to eat on the ground floor. Staff did not tell people what was on their spoon and one staff member did not know what meat they were serving.
- People being nursed in bed didn't get their lunch until after 1.30pm because the staff were supporting people in the dining room. We noted one of the people using the service had received a drink and a plate of sandwiches in their room around 1.30pm. They were still on their table untouched at 3.15pm.
- The head chef knew about people's needs and their likes and dislikes and menus offered two choices for each meal. One of the people using the service told us, "I don't choose my lunch, they just bring it but obviously if you have allergies or needs they adjust it. I love my vegetables and the food here. They bring me my jug of cordial drink, I will drink it and they refill it, I will have up to 4 jugs a day sometimes."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care and support needs had been assessed when they had first moved into the service.
- People were supported to make choices and decisions about their care and support whenever possible.
- Guidance was readily available to enable the staff team to provide treatment and support in line with national guidance and best practice guidelines. This included information on infection control, nutrition and the condition, sepsis.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Changes in people's health was recognised by staff and prompt and appropriate referrals were made to healthcare professionals.
- People had regular access to GP's, dieticians and the speech and language therapy team, and staff sought the appropriate advice when needed.
- The staff team worked together within the service and with external agencies to provide effective care. This included providing key information to medical staff when people were transferred into hospital, so their needs could continue to be met.

Staff support: induction, training, skills and experience

- The staff team had received an induction into the service when they first started working there and training relevant to their roles had been provided. One explained, "I had an induction and I've had first aid training and everything else."
- Registered nurses working at the service had been supported by the management team to meet their requirements for revalidation and maintain their professional registration.
- The staff team were supported through supervision and appraisal and they told us they felt supported by the registered manager. One explained, "The management are approachable, you can always ask the manager anything, she is really nice."

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

- The premises were well maintained and adapted to meet people's needs.
- Communal areas including dining rooms and lounges were available on all floors.
- Work was underway to redecorate and improve areas of the service including painting walls and replacing carpets.

# 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

Requires Improvement: People were not always cared for or treated with dignity and respect. Some regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity

- The staff team didn't always pre-empt or respond to people's needs by picking up on signs. One person was uncomfortable on their bed and lying down flat trying to watch television. The staff walked in and out of the person's room but did not pick up on signs of them struggling to watch the television. Staff did not think to use the beds adjustable back rest to help the person watch the television in comfort.
- The staff team did not always record incidents that caused distress to others. For example, on the day of our visit we observed a person shouting and sounding alarmed when another person walked in to their room and lay down on their bed next to them. Whilst staff responded promptly and supported both people well, they recorded this incident in only one person's care records. There was no record of the impact this had on the other person's feelings, well-being or behaviour. This information would have been useful for staff in case it had impacted on the person's mood or behaviour for the rest of the day or night.
- The staff team did not always have the time to recognise and give people the compassionate support they needed, and with the exception of the people with dedicated one to one hours, have the time to sit and talk with people for a meaningful length of time.
- People told us the staff team were kind and caring. One person told us, "The carers are dedicated and they are excellent."
- Relatives we spoke with agreed their family members were treated in a caring manner. One explained, "The care is good quality, if it wasn't I'd say so." Another told us, "The staff are all very caring, from cleaners to the manager."
- Whilst people told us the staff team were kind and caring, the staff team were often focused on the task in hand and had little time to focus on people's wellbeing.
- Not all the staff members spoken with were knowledgeable about people's life history, though they were aware of the care and support they required. Staff knew people's preferred routines and the people who were important to them. They knew their likes and dislikes and personal preferences. This included the names people preferred to be called.

Respecting and promoting people's privacy, dignity and independence

- Whilst people told us they were treated with respect and their dignity upheld, we observed one instance when this was not the case. One of the people using the service had been provided with their lunch however, they were still lying on their bed and they had their bowl of soup on their chest which they were attempting to eat. They explained they had asked for a tray, but the staff member had not understood. This was neither dignified nor respectful. We brought this to the attention of the management team who immediately assisted them into an appropriate position and provided their meal on a tray.
- Relatives felt their family members were treated with dignity and respect. One explained, "[Person] has

rallied since being here and is on fortified drinks, they treat everyone with dignity and respect."

- The staff team gave us examples of how they promoted people's privacy and dignity. One told us, "I close the curtains and shut the door and cover them [people using the service] when washing."
- We observed the staff team knocking on people's doors before entering their rooms.
- We observed the registered manager and staff team were kind and treated people with dignity and respect. We observed them reassuring people when they became distressed or upset. We saw them address people as individuals. We noted some staff members were more task focused but also observed others including the activities coordinator actively engaging individuals in a kind, caring and person centred way. This was particularly evident on the middle floor
- Some people needed assistance with moving from one chair to another with the use of a hoist. We observed staff carrying this out in the communal areas. Staff made sure that people's laps were covered with a blanket to promote their dignity and they explained to them what was happening throughout the move.

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

- People using the service had been offered a preference of having a male or female carer and this decision had been recorded in their plan of care. However, we noted this decision had not always been adhered to. One person's plan of care stated they did not want a male providing their personal care. A staff member explained, "I think [person] prefers females. Normally they have a male carer down here." We viewed the person's records which showed a male carer had supported them with personal care on the morning of our inspection. Staff members informed us that the management team placed male care workers on the unit because not many females want to work there.
- People had been involved in making decisions about their care and support whenever possible.
- Relatives and friends were encouraged to visit, and they told us they could visit at any time. One relative told us "It's been brilliant here, [person] came here as end of life, they look after [person] and me, they are very approachable, I feel I can take breaks. They feed [person] but when I'm here they also let me feed [person]."

## Is the service responsive?

### Our findings

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

Requires Improvement: People's needs were not always met. Plans of care were not always followed. Some regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People had been involved in the planning of their care whenever possible with the support of their relatives. One relative explained, "Yes we were involved with the care plan and what help was needed."

- Plans of care had been developed when people had first moved into the service. They covered areas such as the personal care people required, nutrition, mobility, and the behaviours people presented.

- The care planning system was electronic and enabled the staff team to enter the support they provided in real time.

- Not all the plans of care seen were comprehensive or included personalised information in them. Plans did not always state what people's routines were, what they liked to wear, or how they expressed themselves.

One person's plan of care for behaviours which may challenge others simply stated, 'Staff to remind [name] that their behaviour is inappropriate'.

- Instructions in people's plans of care were not always followed. For one person who was nursed in bed, their plan of care instructed the staff team to check on them every 30 minutes for their safety. Records showed staff were not always checking on this person every 30 minutes.

- We noted one person who had been identified at risk of falls had been given exercises to complete every day to maintain their movement and balance however, staff members told us they did not have time to complete the exercises with them. Their daily records did not demonstrate they had been supported to undertake the exercises.

- Plans seen had overall, been reviewed monthly or sooner if changes to the person's health and welfare had been identified.

- The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Information within the service was available in large print and pictorial form.

- People were supported to follow their interests and take part in activities. The provider employed two activity coordinators' though only one was working at the time of our visit.

- They supported people to partake in both group and one to one activities. These included cooking sessions, puzzle afternoons card making and pampering days. For people nursed in bed, light therapy was being offered to aid sensory stimulation.

- Whilst evidence was seen of activities being provided, and the activities coordinator was doing their best to offer people activities on the day of our visit, some people with dementia and those who were room based showed some frustration at the lack of stimulation being offered. This was particularly evident for the people on the top floor. When staff were in the lounges, interaction was limited between them and the people using the service. In the afternoon of our visit, people were supported to sit in the garden and enjoy the nice

weather.

Improving care quality in response to complaints or concerns

- A formal complaints process was in place and people we spoke with knew who to talk to if they were unhappy about anything. A relative told us, "We are happy with the care [person] receives, we would say something if we weren't."
- When a complaint had been received, this had been handled in line with the providers complaints policy and investigated and responded to appropriately.

End of life care and support

- People's preferences and choices at end of life where explored. The staff team had received training on end of life care and a policy was in place. For people not wanting to be resuscitated, Do Not Attempt Resuscitation forms were in place within their records informing the staff team of their wishes. One staff member explained, "We sit with people at the end of their life. We put aroma therapy in their room and play soft music in the background."

# 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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

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

- The registered manager had systems in place to monitor the quality and safety of the service. However, the monitoring of staffing levels had not been effective to ensure appropriate numbers of staff were deployed throughout the service to meet people's care and support needs in a safe or timely manner.
- Audits had been carried out on the records held though the shortfalls identified in the records checked, had yet to be picked up through the auditing process.
- The staff team were required to complete a 'new admission 72-hour checklist' when people first moved into the service. We identified these had not always been completed accurately. For a person who had moved into the service in January 2019, their checklist was incomplete. The auditing processes within the service had not identified this.
- Processes for the recording and reporting of bruises had not always been followed.

Whilst systems were in place to monitor the service being provided, these had not been operated effectively to identify the shortfalls found. These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

- Regular audits to monitor the environment and on the equipment used to maintain people's safety had been carried out.
- Staff understood their roles and responsibilities and the registered manager was accountable for the staff and understood the importance of their roles. The staff team were held to account for their performance where required.
- The registered manager understood their legal responsibility for notifying the Care Quality Commission of deaths, incidents and injuries that occurred or affected people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events. They were also aware of their responsibility to have on display the rating from their latest inspection. We saw the rating was clearly on display on the provider's website and within the service.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- Staff demonstrated their knowledge and understanding around such things as safeguarding, whistleblowing, equality and diversity and human rights.



- The registered manager worked in an open and transparent way when incidents occurred at the service in line with their responsibilities under the duty of candour.

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

- People and their relatives had been given the opportunity to share their thoughts of the service being provided. This was through regular meetings and weekly surgeries with the registered manager.
- Surveys had also been used to gather people's views of the service provided. These had been completed by the people using the service and their relatives. Following the return of the most recent surveys, a 'You Said... We Did' action plan had been produced and this was displayed for people's information.
- The staff team had been given the opportunity to share their thoughts on the service and have a say on how the service was run. This was through day to day conversations with the management team, formal staff meetings, supervisions and daily handovers. One staff member explained "I am very talkative, I can talk with them, [management team] and I am always talking to the nurses."

Continuous learning and improving care

- When shortfalls had been identified within the mental capacity assessment process, the management team had acted to make improvements.

Working in partnership with others

- The registered manager worked openly with stakeholders and other agencies. This included raising safeguarding alerts and liaising with social work teams and other professionals when appropriate.

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 12 HSCA RA Regulations 2014 Safe care and treatment  Regulation 12 HSCA RA Regulations 2014. Safe care and treatment.  People were placed at risk because risk assessments were not followed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment  Regulation 13 HSCA RA Regulations 2014. Safeguarding service users from abuse and improper treatment.  There was a failure to record or report potential abuse.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Regulation 17 HSCA RA Regulations 2014 Good governance  The systems used to monitor the service were not effective.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  Regulation 18 HSCA RA Regulations 2014.

## Staffing

Appropriate numbers of staff had not been suitably deployed to meet people's needs in a safe or timely manner.