Lotus Care (Cressington Court) Limited

Cressington Court Care Home

Inspection report

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

Summary of findings

Overall summary

About the service
Cressington Court is a residential care home providing personal and nursing care to up to 56 people. The service provides support to people who live with physical disabilities and dementia across two units. At the time of our inspection there were 47 people using the service.

People's experience of using this service and what we found
People were not always protected from serious harm because staff did not always ensure they received care and treatment in a safe and effective way. People did not always receive their medicines as prescribed. Staff did not always effectively safeguard people or act on recommendations made by safeguarding professionals to reduce risks identified. Accidents and incidents were not effectively managed to prevent further incidents and lessons were not always learnt. We found safety concerns in relation to the environment and infection control. During the inspection the provider acted on our concerns about the environment and improvements were made.

People were not consistently supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's needs were not effectively assessed or reviewed and their care was not always planned in line with best practice guidance. Staff did not always have the skills and experience to provide safe, responsive and effective care and treatment. The provider was highly reliant on the use of agency workers and this meant people did not receive consistent care.

People were not always treated with kindness, respect or compassion because a number of agency staff deployed failed to understand the needs and preferences of people they supported. We received mixed feedback from people who lived at the service and their representatives about staffs' approach and knowledge of their needs. People were not always involved in the care planning process or when decisions were made about their care and treatment.

People were not always supported in a person-centred way. Staff lacked understanding about people's preferences and life experiences this meant they had been unable to build meaningful relationships. Staff did not have the skills or experience to effectively support people at the end of life. People were not always supported to make informed decisions about end of life care in a person-centred or timely way.

The service was not well-led. The registered manager and provider failed to carry out their regulatory responsibilities. Quality assurance processes were ineffective, this meant serious risk of harm was not suitably acted on. During the inspection the senior management team and nominated individual worked in partnership with us and social care commissioners to ensure immediate actions were taken to mitigate the failures highlighted in this report.

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 09 November 2019).

Why we inspected
The inspection was prompted in part due to concerns received about medicines, staffing and clinical care. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We undertook this inspection at the same time as CQC inspected a range of urgent and emergency care services across Merseyside. To understand the experience of social care Providers and people who use social care services, we asked a range of questions in relation to accessing urgent and emergency care. The responses we received have been used to inform and support system wide feedback.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, environment safety, staffing, governance, safeguarding adults, nutrition and hydration, medicines and person-centred care at this inspection.

We originally took action to propose to cancel the providers registration in response to the concerns found. Due to action taken by the provider to reduce the risk of harm to people we have decided to withdraw the action to cancel the provider. Please see the action we have asked the provider to take at the back of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Cressington Court Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by three inspectors, a medicines specialist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cressington 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. Cressington Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
This inspection was unannounced.

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 seven people who lived at the service and eight relatives. In addition, we spoke with 15 members of staff including; the registered manager, the regional operations director, the clinical lead, the clinical educator, registered nurses, senior support workers, support workers, the cook, maintenance staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at 18 people's medicine records, eight people's care records, two staff recruitment files and a number of records in relation to the running of the service.

After the inspection
We looked at evidence submitted by the regional operations director and continued discussions remotely with the senior management team.

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.

Assessing risk, safety monitoring and management
- The provider failed to ensure people were protected from the risk of avoidable harm.
- Staff did not always effectively support people to eat and drink. This exposed them to serious risk of dehydration and malnutrition.
- Staff did not always support people to reposition when in bed, this exposed them to risk of skin breakdown.
- Staff did not consistently ensure people had the right equipment including beds, mattresses and call bells. This exposed them to risk of social isolation, unmet care and emotional needs and physical discomfort.
- The provider's safety monitoring systems were ineffective because failures identified at the inspection were not already known or acted on.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They worked with the local authority and health commissioners to review people's social and health needs and preferences.

- On the first day of the inspection we identified failures in fire safety standards, emergency call bells and environment safety. The provider took immediate action and risks were mitigated.

Using medicines safely
- Medicines management processes were not safe.
- Staff failed to ensure people consistently received their medicines as prescribed. For example, one person had not received their prescribed daily treatment for glaucoma consecutively for one month. Another person had not received their daily prescribed treatment for managing excessive oral secretions for seven days.
- The provider failed to ensure safe and effective oversight of controlled drugs.
- Staff failed to consistently administer people's thickening agents into drinks. This exposed people to the risk of choking and aspiration. One person suffered from a chest infection because their fluids had not been suitably thickened on multiple occasions. This concern was safeguarded by us and visiting health care professionals.
- The provider failed to ensure safe and effective oversight of liquid feeds and medicines administered through a tube direct to people's stomachs (enteral feeding tube). This placed people at significant risk of

harm because they did not always receive the nutrition, hydration or drug therapies they needed.

Systems had not been established to ensure safe and effective administration of medicines. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They worked with the local authority and health commissioners to review people's social and health needs and preferences.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider failed to ensure people were consistently safeguarded from the risk of abuse and neglect.
● During the inspection we identified a number of safeguarding incidents that had not already been identified or suitably actioned by the provider. For example; unexplained pressure wounds to people's skin, bruising caused by unwitnessed falls, failure to carry out clinical care including enteral feed tube site cleaning, catheter care and stoma care.
● We raised a number of safeguarding alerts and received assurances during the inspection people were reviewed by the local safeguarding authority and safeguarding plans were put into place.
● We received feedback from safeguarding professionals who told us the provider did not always act on their recommendations to ensure lessons were learnt when things went wrong.
● The provider failed to ensure effective oversight of accidents and incidents. For example, when medicine errors were reported the registered manager failed to investigate and action in a timely way to prevent further incidents occurring.

Systems had not been established to ensure people were effectively safeguarded from abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They worked with the local authority and health commissioners to review people's social and health needs and preferences.

Staffing and recruitment
● The provider failed to deploy sufficient numbers of staff with the required training and experience to support people with complex health needs. This led to multiple failures in the provision of people's care and treatment including; medicines management, dysphasia and choking, catheter care, stoma care, enteral feeding and wound care management.
● The provider significantly relied on agency nurses and support workers because they had been unable to recruit and retain permanent employees. This meant people did not receive consistent care from staff who had good understanding of their needs and preferences.

Systems had not been established to ensure suitable numbers of trained and experienced staff were deployed to support people who lived at the service. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They improved the induction training process and deployed senior managers to have oversight of the care interventions provided.

● The provider had experienced significant challenges around recruitment and retention of registered nurses. They were considering new ways of working including appointment of oversees nurses.

● The provider followed safe recruitment processes to ensure staff were of good character.
Preventing and controlling infection
● On the first day of the inspection we found shortfalls in the management of infection prevention and control. These included; staff failure to consistently wear face masks and checking of visiting professionals COVID-19 testing.
● On the third day of the inspection we found the provider failed to ensure COVID-19 isolation procedures were followed for one person who returned from hospital, this meant the risk of COVID-19 transmission was not sufficiently mitigated and exposed people to the risk of avoidable harm.

Systems had not been sufficiently established to ensure good oversight of infection prevention and control. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the fourth day of the inspection we observed improved compliance with infection, prevention and control processes. Visitors were permitted to the home in a controlled and person-centred way in line with COVID-19 care home guidance.
● We received positive feedback from people's relatives in relation to the way staff had worked throughout the COVID-19 pandemic.

We have signposted the provider to resources to develop their approach.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People did not always receive effective care and treatment which exposed them to serious risk of harm.
- Some people had received urgent and emergency care because staff had failed to act in a timely manner when their needs were changing. For example, one person had a dangerously low heart rate which had been identified by staff however, not acted on in a timely way. Another person was admitted to hospital because their catheter had blocked due to staff failing to carry out safe catheter care
- During the inspection we found staff deployed by the provider to make immediate safety improvements lacked skills and knowledge to do so safely. For example, we asked the provider to review catheter care. A senior nurse reviewed a person's catheter care plan and risk assessment, they failed to acknowledge the catheter had not been changed as prescribed and was five weeks delayed exposing them to the risk of infection.

Systems had not been established to ensure people were effectively assessed and support carried out in line with best practice standards. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They worked with the local authority and health commissioners to review people's social and health needs and preferences.

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

- The provider failed to ensure people received consistent care and treatment in line with their assessed needs to prevent malnutrition and dehydration.
- A significant number of people who lived on the nursing unit and had lost weight. One person had lost 41kg in six months, staff failed to effectively support them to prevent further weight loss. Another person received unsafe foods on multiple occasions which exposed them to serious risk of harm by choking.
- Staff did not always ensure people had enough fluids to keep them hydrated. People reliant on enteral tube feeding did not always receive the right amount of fluids. One person had lost a significant amount of weight due to not receiving any diet or fluids for three consecutive days.
- We received feedback from external health professionals who told us people who lived on the nursing unit were often found dehydrated when they had assessed them.

Systems had not been established to ensure people were effectively assessed and support carried out in line with best practice standards for nutrition and hydration. This placed people at risk of harm. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They worked with the local authority and health commissioners to review people's social and health needs and preferences.

Staff support: induction, training, skills and experience
● The provider failed to ensure staff were sufficiently trained to carry out safe and effective support for people with complex clinical needs.
● New staff had not received induction training in a timely way. For example, a support worker deployed to support people on the nursing unit had not received mandatory training including moving and handling, pressure area care, nutrition and hydration or health and safety awareness. ● Agency workers deployed as shift leaders and responsible individuals in the case of an emergency had not received an induction including an environmental tour to ensure they could act responsibility in the event of a fire or emergency.
● Staff told us they did not receive a detailed handover at the start of their shift and they did not always know how to support people in a person-centred way.

Systems had not been established to ensure suitable numbers of trained and experienced staff were deployed to support people who lived at the service. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They improved the induction training process and deployed senior managers to have oversight of the care interventions provided.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● The provider had systems in place to assess, review and report on people's mental capacity and decision-making abilities.
● A number of mental capacity assessments were in place from admission for people with impaired cognition and decisions were made in line with principles of the MCA and in people's best interests. However, the provider did not always ensure people's capacity and ability to make decisions was reviewed when their physical and mental health deteriorated.
● DoLS processes were in place and followed.

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

● The environment had been designed and adapted for people with physical health disabilities.
● The residential unit supported people who lived with dementia. The unit was not well designed or adapted to aid people's orientation, stimulation or independence. We discussed this with senior managers who told us work was planned to improve the environment.

Inadequate

Is the service caring?

Our findings

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

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 treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not consistently treated with compassion and kindness because staff did not know about their personal history and preferences.
- People's essential care needs including bathing were not always met and this negatively impacted on their wellbeing. One person told us; "I have not had a shower or a bath in four weeks, the staff just do not have time".
- The provider failed to ensure people consistently received person-centred care and treatment, therefore their abilities were not always fully assessed to ensure their independence was maximised. A relative expressed their concerns, "I am really concerned that [Name] has not been getting out of bed and I'm worried that [Name] legs will be getting weaker. [Name] should be convalescing there and becoming stronger."
- We observed that agency workers failed to understand the needs of people who lived with dementia. This meant people did not always achieve positive experiences and we saw people had heightened emotional distress because staff did not how best to support them.

Systems had not been established to ensure people received person-centred care and treatment. This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They worked with the local authority and health commissioners to review people's social and health needs and preferences.

- People and their representatives told us regular staff were kind and caring. We observed regular staff engaged with people in a compassionate way and during our conversations it was clear staff wanted to drive improvements.

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

- We received mixed feedback from people's representatives about how staff communicated with them. Comments included; "The home doesn't always respond to email or phone calls. I had sent an email and I hadn't received a reply in two weeks," and "The senior always gives us a rundown on [Name's] progress when we arrive."
- We looked at people's care records and found little information about how they had been consulted or

involved in the care planning process.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- The provider failed to ensure people received person-centred care.
- People did not always receive continuity of care. Agency workers had limited understanding about people they supported, this meant people's needs and preferences were often not met. For example, one person had a number of pressure wounds on their skin which meant they needed support from staff to be moved in bed every two hours, we could not be sure they received this support because records indicated gaps of 6-8 hours on some occasions. When we asked an agency worker if they had been moved they informed us they were not aware they had pressure wounds or needed moving every two hours.
- People's care plans and risk assessments were not always up to date and reflective of their current needs. One person's care records stated they had a particular type of catheter to drain urine. However, the catheter in place was a different kind that needed alternative monitoring and care. This meant staff did not have access to correct information to provide safe catheter care.
- On the first day of the inspection we found people had no means to call for support due to a faulty call bell system. This was known by the registered manager however, timely action had not been taken. One person told us they were in a lot of pain however had no way to ask for pain relief.
- People were not always admitted to the service in a person-centred way. This meant the support they received was not always in line with their needs or responsive to changing needs because staff did not have the required information about the persons history to guide them. On admission people or their representatives were not always involved in the care planning process.
- Staff did not have the skills or experience to effectively support people at the end of life.
- People were not always supported to make informed decisions about end of life care in a person-centred or timely way.

Systems had not been established to ensure people received person-centred care and treatment. This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They worked with the local authority and health commissioners to review people's social and health needs and preferences.

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 care plans included information about their communication needs in relation to vision and hearing. People had been reviewed by external health care professionals and prescribed visual and auditory aids when needed.

● Accessible formats of communication for people with impaired vision or cognition were not in place to aid their understanding and involvement.

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

● Staff did not always effectively support people who were nursed in bed to maintain connection with current affairs, interests or cognitive stimulation. People who were nursed in bed had not been assessed in a holistic way to consider alternative ways to facilitate sitting in communal areas to avoid social isolation.

● People who were able to access communal areas had regular access to group activities. However, people who lived with dementia and unable to engage in group activities such as the quiz or creative sessions did not.

● People and their representatives told us they felt connected and able to visit in line with COVID-19 care home guidance. The provider supported visitors to undertake testing prior to arriving at the service and informed them if visiting was not deemed safe due to COVID-19 outbreak.t have access to meaningful activities in line with their abilities and interests.

Improving care quality in response to complaints or concerns

● People who lived with dementia did not have access to the complaints process in an accessible format.

● People and their representatives told us they felt confident to raise concerns and complaints.

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 widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider and registered manager failed to ensure the service was consistently well-led. There was a lack of effective quality assurance therefore, shortfalls found at this inspection were not already known or suitably acted on.
- The provider and registered manager failed to ensure compliance with regulatory standards including environment safety, risk assessment and mitigation, medicines management, person-centred care, nutrition and hydration, staffing and infection control processes. This had resulted in people had being exposed to the risk of avoidable harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Continuous learning and improving care

- The provider did not always ensure safeguarding concerns were acted on in a timely way.
- Staff failed to identify when people's needs were deteriorating, this meant people did not always receive timely health care reviews.
- External professionals told us the registered manager did not always act on their recommendations and this meant people's health and wellbeing deteriorated. For example, one person had been reviewed by a swallowing specialist and prescribed thickened fluids to prevent them aspirating. Staff did not consistently follow their advice, this led to the person experiencing a decline in their physical health.
- There was a limited approach to obtaining people's views and feedback. One person recently admitted to the service told us they had not been involved in any care planning discussions and was unaware of why they were unable to return home.
- The provider failed to demonstrate effective learning and improvement because shortfalls identified throughout the inspection were not sufficiently mitigated by the provider. The provider failed to have suitable oversight of staff performance and this meant unsafe care and treatment was delivered.
- We received mixed feedback from people's representatives about the running of the service. Comments included; "The manager helped with the initial 28-day trial when [Name] went into this home. The members of staff are all approachable and will listen. I have no concerns at all," "I usually ask [the manager] to do things when I speak to her. I don't trust her though," and "When I ring up [the manager] always says that she doesn't know any particular information about my dad and passes me straight through to the [unit]."

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

outcomes for people

- The provider failed to promote a positive person-centred, inclusive and empowering culture. People's basic care needs were often not met, this placed them at serious risk of emotional and physical harm.
- Leaders within the organisation had not identified the poor culture within the service.

Systems were not effective to ensure good governance of the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They worked with the local authority and health commissioners to review people's social and health needs and preferences and improved senior management oversight to ensure improvements would be sustained.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Systems had not been established to ensure people received person-centred care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to ensure safe and effective administration of medicines. Systems had not been sufficiently established to ensure good oversight of infection prevention and control. Systems had not been established to ensure people were effectively assessed and support carried out in line with best practice standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been established to ensure people were effectively safeguarded from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

Treatment of disease, disorder or injury	Systems had not been established to ensure people were effectively assessed and support carried out in line with best practice standards for nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Systems were not effective to ensure good governance of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Systems had not been established to ensure suitable numbers of trained and experienced staff were deployed to support people who lived at the service.