St. George's Care Ltd

St George's 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
St George's Home is a care home providing personal care for up to 29 older adults. At the time of our inspection 24 people lived at the home, some people were living with dementia.

People's experience of using this service and what we found
Lessons had not been learned since our last inspection. The quality and safety of the service had deteriorated since our last inspection and some previous standards had not been maintained. The provider's systems and processes designed to identify shortfalls, and drive improvement were not robust and remained ineffective. The providers oversight of the service provided was poor and the manager lacked knowledge of regulatory requirements which meant opportunities to make improvements were missed. The management team were being supported and were working closely with local authorities to improve outcomes for people.

People did not receive good quality, safe care. Information staff needed to help them provide care safely was not always available to them and staff did not always follow instructions to manage risks associated with people's care. Environmental risks including fire safety had not been identified, assessed, and mitigated to keep people safe. Action had not been taken to improve fire safety since our last inspection.

People told us they felt safe, and staff knew what action to take if they thought someone was at risk of harm. Medicines were not managed safely in line with the providers policies and best practice medicines guidance.

Enough staff were employed to meet people needs but the provider's recruitment practices were not safe. Areas of the home were dirty, and improvements required in relation to the prevention and control of infection had not been made. The provider's staff recruitment practices were not safe or robust.

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

Staff were not suitably trained to meet people's needs. Most people and their relatives told us staff provided effective care, but we saw how the lack of staff training negatively impacted on people's safety and experiences and training staff had completed was not always effective.

The environment did not support people's sensory needs and sufficient signage was not in people to help people orientate themselves around their home. Some relatives told us the environment needed to be redecorated to ensure the home was a nice place for people to live. Our observations confirmed redecoration and refurbishment was needed.

People spoke positively about the food and drinks provided, however the mealtime experience needed to be improved. Staff did not always offer the timely support people needed to enjoy their meals.

People had access to health professionals which supported their health and wellbeing. People felt listened to and provided positive feedback about the manager. Relatives told us the manager was approachable and that communication between them and the service was good. Staff felt supported and enjoyed working at St George's Home.

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 14 December 2022). There were breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

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

Why we inspected
The inspection was prompted due to concerns we received about the quality and safety of the service provided. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St George's Home on our website at www.cqc.org.uk

Enforcement
Following our inspection visits, we asked the provider to respond to the immediate concerns we found. We continued to seek their updates and assurances they had mitigated the immediate risks to people.

We have identified a continued breach in relation to governance and identified further breaches in relation to safety, safeguarding and staffing.

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

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

Follow up
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.

Special Measures
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 of 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

St George's 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.

Inspection team
The inspection was undertaken by 2 inspectors 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
St George's Home 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. St George's Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. The manager had submitted an application to register with us.

Notice of inspection
The first of our inspection visits was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from two local authorities who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people who live at the home and 9 relatives about their experiences of the care provided. We spoke with 11 members of staff including the manager, the compliance manager, care assistants, senior care assistants, the cook, a domestic assistant, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at a range of people's care records and multiple medicine records. We reviewed records relating to the management of the service including, staff training data, fire safety records, some policies and procedures and the recruitment records for 3 staff members.

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

- Risk management was inadequate. Environmental risks were not identified, assessed and mitigated.
- Multiple fire safety risks posed a significant risk of harm to people. For example, 4 fire doors did not fit securely into their rebates. Those fire doors would not close securely to prevent a fire from spreading through the home.
- At our last inspection some fire doors were wedged or propped open. Those concerns remained at this inspection. This was unsafe as the doors could not close in the event of a fire to keep people safe.
- The annual fire safety risk assessment completed in March 2023 by a specialist fire safety company had identified the provider was not meeting fire safety legislation requirements. The remedial actions needed to mitigate these risks had not been taken. This was unsafe.
- The external vent pipe for the tumble dryer in the laundry was positioned at a low level in the garden. The pipe was uncovered, was hot to touch and hot steam blowed out of the pipe. This exposed people to the risk of avoidable harm or injury. We bought this to the managers attention. They were not aware of this risk.
- The garden area was also not safe for people to use as discarded equipment created a falls risk.
- The management team had failed to ensure equipment was safe for people to use. We saw the rubber ferrules on 2 people's walking frames had worn away which exposed the metal frame. The manager confirmed checks of walking frames did not take place.
- Staff did not always have the information they needed to provide safe care because risks associated with people's care had not always been assessed. One person was at risk of choking on food, but the risk had not been assessed until we bought it to the attention of the manager. The person's care records also contained conflicting information about the foods they could consume safely.
- Other people's care records contained inaccurate information. One person's records stated mirrors needed to be removed from their bedroom as seeing their reflection caused them distress. The manager confirmed this was incorrect and had been caused by a recording error.
- Staff had not always followed risk management plans to keep people safe. One person had fallen 4 times since February 2023. To mitigate this risk staff were instructed to check the person's walking frame was safe for them to use every week. No checks had been completed.

Systems and processes did not demonstrate risks were always identified, assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Due to the seriousness of some fire safety risks we wrote to the provider twice to ask them to take urgent remedial action. In response we received an action plan which informed us how and when risks would be

mitigated to improve fire safety.
● During our visits some action was taken to mitigate risks. For example, discarded equipment was removed from the garden area to make it safer for people to use.

Using medicines safely
● Medicines were not managed safely in line with the providers policy and best practice guidance.
● Medicines had not always been administered in line with prescribing instructions. One person's medicine needed to be administered at specific times to manage their pain. On day one of our inspection the medicine was administered over 2 hours late and was only administered when we alerted the manager to this. Furthermore, 2 doses of the medicine were given to the person too close together. This posed a risk to the person's health.
● We identified anomalies between the number of some medicines in stock and the number recorded as received and administered. For example, 2 people had more tablets in stock than they should have. The manager was unable to provide an explanation for this or demonstrate those people had received their medicines as prescribed.
● Protocols to inform staff when medicines prescribed 'as required' needed to be administered were not always in place. That meant people could have been given too much or not enough of their medicine.
● Risks associated with the use of emollient creams that contained flammable ingredients had not been assessed. This is important as the build-up of cream residue on bedding and clothing makes those fabrics more flammable which can result in serious or fatal injuries from fire. The manager was not aware of this significant risk.
● Some prescribed creams in use did not have a prescription label or their dates of opening recorded. The provider could not be sure who the creams belonged to or demonstrate the creams were being used within recommended timescales and were effective.
● Some staff had not completed required medicines training. One staff member told us, "I put the cream on the resident's skin, but I've not done training." They added, "The other staff told me what to do."
● Medicines had not been disposed of safely. An unlabelled bottle in the medicine's cupboard contained multiple different tablets. The manager was unable to confirm who the tablets had been prescribed for, why they hadn't been administered or how long they had been in the cupboard. This was poor medicines practice.
● Audits of medicines remained ineffective. They did not check all the medicines in use and had not identified the issues we found. We identified similar concerns in October 2022. This showed the providers oversight of people's medicines continued to be poor.

Medicines were not managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not recruited safely. The provider had failed to ensure robust recruitment processes were followed. This failure exposed people to the risk of receiving care from unsuitable staff.
● Recruitment records were not available for all the staff who worked at St George's Home. The manager and compliance manager could not locate any recruitment checks for a staff member who was on duty during our visits.
● Recruitment records for a second staff member lacked important information. The provider could not demonstrate they had sought proof of the staff members identity or obtained references to evidence their conduct or suitability for their role. In addition, gaps in their employment history had not been explored. The compliance manager confirmed the gaps should have been investigated in line with the providers policy and procedure.

● A third staff member told us they had worked at the home for about a month. The provider could not demonstrate recruitment checks had been completed prior to their employment commencing. The checks in their recruitment file had been completed by another care home that was not part of the same provider group.
Systems had failed to ensure staff were recruited safely. This was a breach of Regulation 19 (2) Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from people and their relatives confirmed enough staff were on duty to meet their needs.
● Staff told us there was enough of them to provide the care and support people needed in a timely way. Our observations confirmed this.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Multiple areas of the home including people's bedrooms, the laundry and the lounge were very dirty. Some equipment in use was rusty, and paintwork was chipped and scuffed which meant it could not be cleaned effectively. This demonstrated sufficient cleaning did not take place to prevent and control the spread of infections. Furthermore, people's clothing was not laundered in line with best practice. We had identified similar concerns at our last inspection.
● We were not assured that the provider's infection prevention and control policy was up to date. The policy had been reviewed in January 2023, but it did not align with current guidance.

Risks associated with preventing and controlling the spread of infection had not always been identified or mitigated. This placed people at risk of harm and was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was using PPE effectively and safely. We saw staff wore PPE however, some staff could not recall completing training in relation to this.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
Visitors were welcomed during our visits. No visiting restrictions were in place.

Systems and processes to safeguard people from the risk of abuse.
● The provider was unable to demonstrate all their staff had completed safeguarding training. However, staff described the actions they would take if they thought someone was at risk of harm. One staff member said, "If something is wrong, like an injury or bruise I would report it. I report to the senior or the manager."
● Nine out of the 10 people spoken with felt safe living at St George's Home. One person said, "I'm happy here, I feel safe. Everything is closed up on a night. The girls are nice, they make me feel safe."
● Seven out of the 9 relatives spoken with had no concerns about their family members safety. One relative said, "He is very safe. I think the care is impeccable." In contrast 2 relatives stated they did not feel their relatives always received safe care. They told us social workers were helping them to find somewhere else for their loved ones to live.
● Whilst our inspection findings evidence the service was not safe staff told us people did receive safe care. One staff member said, "The residents are safe here. They are happy. The seniors and manager do

everything to keep them safe. The residents' families are happy that they are here."
● A safeguarding policy was in place and the manager had shared information with the local authority safeguarding team and us (CQC) to ensure allegations or suspected abuse were investigated.

Learning lessons when things go wrong
● Lessons had not been learned. Our inspection findings evidence the quality and safety of the service had significantly deteriorated since our last inspection. Many of the risks and concerns we identified at previous inspections had not been addressed.
● Accidents and incidents had been reported by staff. A staff member said, "If anyone falls, we fill in an accident form to make sure it's documented, and we tell the family."
● The manager analysed incidents including falls to prevent recurrence. For example, a crash mat had recently been put into place to prevent a person being injured if they fell out if bed.

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 inspection in 2020 we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed.

When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider was not compliant with the requirements of the Mental Capacity Act 2005 (MCA). This meant people were at risk of receiving improper treatment.
● One relative shared their loved one lived with dementia and required constant supervision from staff to remain safe. The manager and staff told us they would not let the person leave the home alone as it would be unsafe for them to do so. An application to restrict the person's liberty had not been submitted as required in line with legislation. This meant the person's liberty was being restricted unlawfully.
● The provider had not maintained sufficient overview of authorised restrictions. Information shared with us did not provide an accurate picture of which people had authorisations in place, what they were for or when they expired. Furthermore, conversations with the manager, compliance manager and staff confirmed they did not know who had restrictions in place. We found the same concerns at our last inspection in October 2022.

People were at risk because systems and processes had not ensured people were protected from improper treatment. People were unlawfully deprived of their liberty. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People's capacity to make decisions had not always been assessed when required. Care records did not

document whether people had capacity to consent to specific aspects of their care. Best interest decisions had not been made when needed to demonstrate people's care was provided in the least restrictive way to ensure their rights were upheld.
●The manager lacked knowledge of the MCA and was unable to explain the process they would follow to assess a person's capacity if they thought they were unable to make particular decisions.
● People confirmed staff sought their consent before they provided assistance during our visits. We saw that happened.

Staff support: induction, training, skills and experience
● Staff had not completed training the provider considered essential and our observations confirmed staff did not have the knowledge and skills needed to provide safe and effective care to people.
● The lack of staff training impacted negatively on people's safety. Two staff members used an unsafe moving and handling technique when they assisted a person to move. This exposed the person to the risk of harm or injury. We immediately bought this to the attention of the compliance manager for them to address.
● Some staff could not recall completing moving and handling training and explained they had been shown by other staff how to move people.
● Accurate and up to date training records were not maintained. One training matrix reviewed did not include all staff employed at the home. The second matrix reviewed contained significant gaps which meant the provider could not demonstrate their staff had completed the training they needed to meet people's needs, including safeguarding, moving and handling, medicines and MCA. Despite our request for accurate training information, this was not provided.
● Training staff had completed was not always effective. For example, some staff who had completed fire safety training in March 2023 could not describe what action they needed to take in the event of a fire to keep people safe.
● The provider had failed to ensure staff had the time they needed to complete training. Staff comments included, "Now days we are doing online training. I have 43 modules to do. You have to do it in your own time," and, "I've been assigned lots of training but if I am honest, I haven't started any of it yet."
● The manager had not completed any qualifications or training to help them keep up to date with legislation and best practice to manage the home effectively. They told us they had signed up to complete a qualification, but the training provider had changed so they had not started it.

Staff were supported to have the right skills, knowledge and understanding to perform their roles safely and effectively. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The majority of people and relatives spoken with had confidence in the abilities of staff. Comments included, "I think they (staff) are trained. They are very good," and, "The majority of staff are trained. A few of them are young and inexperienced, but I've had no problems."
● Staff told us they had completed an induction when they had started work at the home. They explained this had included working alongside other staff which had helped them to get to know people.

Adapting service, design, decoration to meet people's needs
● Some people lived with dementia, but consideration had not been given to support those people with their sensory needs. During both of our visits 2 televisions were on showing different programmes in the lounge. In addition, signage displayed to support people orientate the way around their home was not sufficient.
● Two relatives told us the environment would be improved if the home was redecorated. One commented, "If anything could improve it would be to decorate everywhere. It needs a lick of paint."

● Whilst people spoke positively about the environment the décor furnishings looked old and tired. Some communal areas and bedrooms needed refurbishment to ensure the environment was a nice place to live in. We saw wallpaper was peeling from the walls, paintwork and plaster on the walls was damaged and there were no curtains in the lounge.

Supporting people to eat and drink enough to maintain a balanced diet
● People's mealtime experience was not always positive. During the morning of first visit, people sat waiting for over 30 minutes for the cook to arrive at the home before they were offered any breakfast.
● On day 1 of our inspection the atmosphere in the dining room at lunchtime was not relaxed. We heard people shouted out asking for condiments and cutlery. Staff did not respond in a timely way to people's requests.
● Staff did not always offer appropriate support to ensure people enjoyed their meals. One staff member stood up whilst they assisted a person to eat their meal. This approach was not dignified. We bought these concerns to the attention of the manager for them to address.
● People told us they had enough to eat and drink. One person said, "The food is not bad at all. There is always a choice, and we get a choice of pudding every day. We are offered biscuits and drinks throughout the day."
● The cook knew what people liked to eat and drink and was aware of people's dietary needs. They said, "I have a list in the kitchen with all the resident dietary needs. If anyone has a special diet, I know all about it." Many people provided positive feedback about the cook and the quality of meals they provided. Relatives shared that viewpoint.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed before they moved into St George's Home. The manager told us the assessments were used to support person centred care. These assessments had considered people's protected characteristics and their cultural and religious needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to health professionals including their GP. One person told us a district nurse visited them daily to administer their medicine which managed their health condition.
● Staff worked with other healthcare professionals, such as dietitians and the local care at home support team to support people's health and maintain their wellbeing.

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 this key question was rated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

At our last inspection the provider had failed to have effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Lessons had not been learned. The provider has failed to achieve an overall rating of good at St George's Home since 2016 and has not complied with regulatory requirements since 2018. The multiple breaches of the regulations we identified at this inspection demonstrate the quality and safety of the service had significantly deteriorated since our last inspection.
● The providers continued lack of service oversight meant they had failed to identify their policies and procedures were not consistently followed, including medicines management and safe staff recruitment. This lack of oversight placed people at risk.
●The provider had failed to achieve the improvement actions detailed in their action plan submitted to CQC following our inspection in October 2022. For example, action had not been taken to prevent, detect and control the risks associated with infections.
● The providers systems designed to monitor the quality and safety of the service remained ineffective. For example, medicine audits did not check all aspect of medicines management and no audits or checks of the service had been completed by the manager and compliance manager. That meant opportunities to improve people's care were missed.
● The provider had failed to effectively assess, monitor and mitigate risks relating to the health, safety and welfare of people and staff. Risk associated with people's care and the environment had not been assessed. Action had not been taken to address significant fire safety risks identified by an external fire safety assessor in March 2023 until we wrote to the provider to ask them to take urgent action. This was unsafe and exposed people to the risk of avoidable harm.
● The provider had failed to ensure the manager and staff had the skills and knowledge they needed to ensure safe care and support was provide to people. Our observations of poor practice confirmed this put people at risk.
● The provider had not met their responsibilities in relation to Mental Capacity Act 2005.

The providers policies and procedures and systems to assess, monitor and improve the quality and safety of the service remained ineffective. Accurate, complete and contemporaneous records in respect of each person were not maintained. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In response to our feedback the nominated individual told us they would support the manager and the compliance manager to make improvements which included implementing a more robust audit of medicines.
● The provider was working with 2 local authorities to make improvements to benefit people. An action plan created by a local authority was in place. The manager told us they would use the action plan to make improvements and monitor any progress made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Whilst our inspection findings evidence the service was not well led people spoke positively about the manager and the leadership of their home. One person said, "The manager is really nice."
● People told us they felt listened to and minutes from meetings and quality questionnaires completed in the 6 months prior to our visit's showed people were happy with the care and support they received.
● Relatives told us the manager was approachable and they had opportunities to attend meetings to talk about the home and the service provided. One relative explained they were kept up to date with any changes in their family members needs which made them feel involved.
● Staff enjoyed working at the service and told us the culture was inclusive. Comments included, "I've had a meeting with (manager) and the seniors. They all help me. They explain things to me and show me what to do," and, "We have team meetings. I feel I'm working with a wonderful team who can speak about your concerns, and something is done. They do listen."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager demonstrated some understanding of the duty of candour. They told us they understood the importance of being open and honest when things went wrong.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) (d) (e) (g) (h) HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people's care and treatment was provided in a safe way. The provider had not ensured risk associated with people's care and treatment, the environment, medicines, equipment, infection prevention and control were identified, assessed and well managed. The provider had not taken all reasonably practical steps to mitigate risks.

The enforcement action we took:

Notice of proposal to cancel the providers registration

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 Regulation13(1) (2) (4)(b) 5 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not ensure people were protected from improper treatment. The provider had not ensured people were deprived of their liberty lawfully.

The enforcement action we took:

Notice of proposal to cancel the providers registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 17 (1) (2) (a) (b) (c) (d) HSCA RA Regulations 2014. Good governance The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured they had effective systems and processes in place to identify assess and mitigate risks relating to the health and safety and welfare of service users. The provider had not ensured records relating to the care and treatment of each person using the service were accurate and up to date.

The enforcement action we took:

Notice of proposal to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (1) (a) (b) (2) (a) (b) HSCA RA Regulations 2014 Fit and proper persons employed. The provider had not ensured their recruitment procedures were operated effectively.

The enforcement action we took:

Notice of proposal to cancel the providers regsitration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation18(1) (2) (a) (b) HSCA RA Regulations 2014 Staffing The provider had not ensured their staff were suitably qualified and had the skills and knowledge the needed to provide care to service users.

The enforcement action we took:

Notice of proposal to cancel registration