Stocks Hall Care Homes Limited

Andrew Smith House - Nelson

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

Summary of findings

Overall summary

About the service
Andrew Smith House is registered to provide nursing and personal care for people living with dementia, older people, physical disability, nursing care and mental health care needs. The service can support up to 60 people. At the time of the inspection, there were 55 people who lived in the home. Accommodation is provided over 4 units on two levels. However, at the time of the inspection the two upstairs units were being run as one unit. This unit specialised in providing care to people living with dementia.

People's experience of using this service and what we found
The service was not safe. A safeguarding referral was raised during the inspection, as we witnessed a staff member ignoring requests for a person to go to the bathroom. We observed other people being left wet and observed some unsafe moving and handling procedures. Some vulnerable people in their rooms were calling out for staff support and it was unclear how often staff were checking on them and re-positioning them. Medication not been managed safely and staff were not recruited safely. There were concerns around infection control and staff we observed were not wearing gloves and aprons. Staffing levels were low. Staff told us they felt under pressure and there was a lack of permanent nursing staff on the complex unit. Agency staff were supporting complex individuals on 1-1's and did not have access to relevant information about the people's needs.

Staff did not always receive appropriate inductions and there was a lack of training for new staff. Staff were generally caring and tried hard to support people as best they could in the difficult circumstances. However, we saw a minority of agency staff who were not compassionate towards people and a safeguarding referral was raised during the inspection. Complaints were not being managed effectively and people did not always feel listened too. People were not consulted about meal choices and the menus were not displayed. Activities were taking place but some people we spoke with felt these were minimal and there was not enough stimulation.

Care plans were detailed. People were 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 supported this practice.

A new manager had recently started at the service, who was in the process of registering to be the registered manager. He was keen to improve the service. However, there had been a succession of managers at the home and people told us that the service had deteriorated. We could see that although some audits had taken place, there was a clear lack of leadership and oversight of the service and staff had contacted us to express concerns about the management of the service. During the inspection the provider met with us and agreed some interim measures to ensure that the risks were minimised.

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) and there was one breach of regulation. 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 that improvements had been made in the area of mental capacity and was no longer in breach, we found further breaches of regulation.

Why we inspected
The inspection was prompted in part due to concerns received about the management of the service. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to medicines, dignity and respect, infection control, staffing, recruitment, acting on complaints and good governance.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe section below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective section below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring section below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive section below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led section below.	**Inadequate**

Andrew Smith House - Nelson

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector, a medicines inspector, a nurse 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
Andrew Smith House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The manager was in the process of applying to be registered. This means that once registered 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
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service, such as notifications. These are events that happen in the service that the provider is required to tell us about. We also sought

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

During the inspection
We spoke with four people who used the service and two relatives about their experience of the care provided. We spoke with eight members of staff including the cook, the manager and the operations manager. We also met with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found and looked at training data which was sent to us following on from the inspection.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse.
- Several safeguarding's and concerns had been raised about the quality of the care prior to the inspection. One recent safeguarding regarding inappropriate staff conduct had resulted in some staff being dismissed and disciplined. During the inspection we observed one individual becoming extremely distressed because a staff member was continually ignoring their requests for assistance to the bathroom. We raised a safeguarding in relation to this and discussed this with the manager who told us the agency staff member had been told to leave and that it was being addressed with the agency.
- We noted that some people had wet themselves whilst waiting for staff to attend to them.

The provider failed to ensure that people were treated with dignity and respect. This is a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Recruitment was not safe.

We looked at three staff recruitment files and found that all three staff had started before appropriate police checks had been undertaken. Recruitment files were disorganised and administrative staff were undertaking a staff file audit. They had identified missing pieces of information in several staff files.

- We saw that the application forms did not request a full employment history and there were gaps in people's employment histories. We asked the manager to follow up on the missing information.

The provider failed to ensure that safe recruitment processes were being used. This is a breach of regulation 19 (Fit and proper persons employed)

- Staffing levels were not appropriate. There had been an increase in numbers and complexity of residents since the last inspection. The upstairs units had been amalgamated into one. This meant the person in charge of the unit was responsible for 32 people. Staff and relatives told us the home was short staffed and one staff said several staff had left due to the pressures they were under. We discussed this with the provider during inspection who agreed immediate actions to ensure that each unit would be separate and would have its own staff team. The nominated individual assured us the deputy manager would be based on the unit and they would oversee this.
- Agency staff were supporting complex individuals with little information about them as they did not have access to the electronic care planning system. One agency staff told us they were sitting outside the

bedroom on 1-1 as the individual was aggressive. They could not explain why, as they had not read the care plan. On the second day of inspection we noted that agency staff had some written information in a file. The provider told us that in-house staff would be supporting people on 1-1 to ensure continuity.
● Staff did not have the time to care people in the way they wanted to. One staff became upset when we raised concerns about one individual and said, "We do care. We need more staff to have time to help her." Staff told us they felt stressed and under pressure.
● We heard people shouting out for staff support and it was not always clear how often people were being checked on and being repositioned. We overheard residents saying they had been waiting a long time for staff assistance. We saw some of the impact of this was that people were unable to access the toilet quickly enough.

The provider failed to ensure staffing levels were appropriate. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely.
●Controlled drugs were not stored appropriately. They were kept with the main stock of medicines in cabinets which did not comply with the Misuse of Drugs (Safe Custody) Regulations 1973 as amended.
●There were gaps in the fridge and room temperature records which meant that it was not possible to ensure that the medicines had been stored at the correct temperature. In one fridge several boxes of insulin were wet and damaged. There was no scheduled check of the fridges to ensure that they were clean and that medicines were stored correctly. Medicines, creams and thickening agents were not always dated when opened.
● Staff were not always administering medication appropriately, for example, the amount of water used to administer a medicine was not measured to ensure it was the correct amount and records indicated that some medicines were not administered due to unavailability. Records did not always include the name of the GP and codes to record non-administration were inconsistent. The location for application of creams and patches were not always recorded on body maps.
● The stock levels of medicines did not tally with the amount recorded on the MARS which meant that they were not an accurate record of the number of medicines available for administration. Disposal records were not always witnessed and some information relating to homely remedies were either missing or had not been updated.
● Protocols to support the administration of medicines prescribed on a when required basis had not been completed for some people and some medicines had not been listed on the MAR chart.

The provider failed to ensure medication was managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Infection control was not being managed safely.
● Staff were not wearing personal protective equipment such as gloves and aprons when carrying out personal care and cleaning tasks.
● The lounge on the dementia unit had an overwhelming odour of urine and we observed staff were not ensuring that chairs were disinfected appropriately. The tables and chair arms were not always clean and had dried food on them.

The provider failed to ensure that infection control was managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risks were documented and strategies around managing people's behaviours were in place. Intervention plans appeared appropriate to the perceived level of risks. We noted that the care plan for one person indicated that staff should complete ABC (Antecedent, Behaviour, Consequence) forms, however it was not clear who reviewed these or how the information was used to support staff. We discussed this with the manager who agreed these would be reviewed and predisposing factors such as pain and miscommunication would be considered.

● Equipment was stored safely, and we saw records to indicate that regular safety checks were carried out. However, we saw that the entrance to the ground floor fire exit was a single door within a cluttered conservatory. We raised this with the manager who addressed this.

Learning lessons when things go wrong

● The manager was able to give examples and demonstrate how he learned from previous mistakes. The manager was keen to improve standards at the service and we observed a meeting in which issues raised on the first day of inspection had been passed onto the staff team.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated 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.

At our last inspection the provider had failed to ensure that legal consent for care and treatment was obtained from people. This was a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

- The provider was working within the principles of the MCA. Where needed, mental capacity assessments and best interest meetings had been completed. The correct procedures for applying for DoLS had been followed.
- Records contained evidence to demonstrate care planning was discussed and agreed with people and their representatives. Throughout the inspection we observed staff sought peoples consent before supporting them with personal care needs.

Staff support: induction, training, skills and experience
- Staff had not always received appropriate induction and training. Observation of training records confirmed that some staff had not received an induction, which meant they did not have the appropriate skills to support people with their care. We found that of the three staff records that we looked at, none of

the three staff had received an induction. One of these staff one had not previously worked in care. We could not locate any of three staff's training records on the computerised system and we were told that one staff's personal file could not be located.

● Staff were supporting complex individuals who had histories of violence and mental health difficulties. No training was provided for staff in the area of mental health. Similarly, staff were supporting people with learning disabilities at the service and had not received any learning disability training. We discussed our concerns with the nominated individual who told us that they would respond immediately and ensure that staff had specialist onsite training that was tailored to the people's individual needs.
● There was a high staff turnover at the service and morale was low. Some had expressed concerns of bullying and these were being investigated.

The provider failed to ensure that staff were appropriately trained and had an appropriate induction. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they were in the process of changing their training provider and that they had plans to improve the training.
● Relatives, however felt the staff were doing the best they could. One relative told us, "The staff are doing a fantastic job in difficult circumstances.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to maintain a balanced diet.
● Prior to inspection we had been made aware of concerns around food. Some staff had alerted us that at times there didn't seem to be enough food. During inspection we observed that there was no system in place for people to order meals which would ensure that the appropriate amounts of food was made and there was less waste.
● Menus were not displayed so people did not know what they were having for lunch. Staff confirmed that they were unsure what was on the menu and this caused difficulties for people. One staff confirmed that there had been issues with ordering stock and the kitchen had run out of basic essentials, such as breakfast cereals. We raised this with the manager and spoke to the cook who told us that due to staff shortages they were struggling to ensure that ordering was done regularly. The manager had been unaware of this issue. We were told that a second chef had been interviewed and was due to start at the service which would alleviate the problem in future.
● People's dietary needs had been recently updated and these were in a file in the kitchen. However, the information on display was outdated and was taken down during the inspection and we were advised that this would updated immediately.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care plans were detailed. However, people with a learning disability within the service did not have any specific care plans such as health action plans and health passports. One person's care plan referred to them using Makaton and British sign language, however there was no evidence within the care plan of a communication passport or inference to support staff to know what signs the person uses.
● Care planning was focussed around older adult services and did not appear to be indicative of the needs of younger people or those with a learning disability. We recommend that the service addresses this issue and seeks guidance around assessing and meeting the needs of people with learning disabilities.
● The service had not been developed and designed in line with the principles and values that underpin

Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that was appropriate and inclusive for them.

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

- The premises were generally well maintained and did meet people's needs.
- The young person's service was being decorated during our visit. We noted paint fumes were strong with no evidence of ventilation.
- The emergency response call through the "Nurse call" system was not working in the day room or the office area. We raised this with the manager who ensure that this was addressed.
- We noted a shower had been out of order for four months. The manager ensured that this was actioned following our inspection.
- Most people's bedrooms were personalised and there was dementia signage to orientate people with dementia to bathrooms and toilets. However, although memory boxes were in place outside some people's rooms, these were not currently being utilised.

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

- Staff supported people to access appropriate support.
- The manager worked with healthcare professionals to ensure people were supported to maintain good health and told us they had access to healthcare services when required. However, we noted some people's oral health care needs had been overlooked. We raised this with the manager and recommended that the service ensure oral health needs are prioritised.
- Care records confirmed visits to and from GPs and other healthcare professionals had been recorded.

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always supported by caring and respectful staff.
- A safeguarding was raised during inspection around an agency staff member and their treatment of an individual. This meant that our rating for this key question is requires improvement.
- People told us staff were kind and most of our observations confirmed this. We observed one staff at lunchtime who interacted kindly and supported an individual to eat at a pace to suit them.

One person told us, "The staff are nice but there's so many new staff all the time. We have seen a lot leave."
- People told us that some staff seemed to genuinely care but often didn't have enough time to care effectively. Relatives told us certain care staff went above and beyond in caring for their loved ones. One person told us, "The staff are kind, they are good."
- Care records seen had documented people's preferences and there was information about their backgrounds. Relatives told us they felt welcome and there were no restrictions on visiting.

Supporting people to express their views and be involved in making decisions about their care
- Staff supported people with decision making and were involved in decisions about their care.
- One staff raised the issue of a resident who had asked to vote and discussed how the staff could help register him to vote and facilitate this.
- People and their relatives had been encouraged to express their views about the service through customer comment surveys. However, resident meetings had not taken place since December 2018. A resident's meeting had been planned by the new manager and this took place shortly after our inspection.

Respecting and promoting people's privacy, dignity and independence
- People's dignity and respect was not always promoted.
- We observed some situations where people's personal care needs were not attended to in a timely way which caused them discomfort and distress.
- Staff we observed were generally courteous and we saw them knocking on people's doors and affording them privacy. We observed staff asking consent and explaining what they were doing with people.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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

.● Care records contained documents reflecting each person's assessment of needs. Staff told us they felt the information provided them with guidance about people's specific needs and how these were to be met. These included people's personal care needs and social interests.

● Agency staff, however, did not have access to the care records and this was addressed during the inspection.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The manager was aware of the AIS and told us the service would provide large print information for people with visual impairment and they would seek information in a range of different formats as necessary to meet people's needs.

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

● People were supported to take part in activities.

● We were told that people had trips out. However, a planned trip to Blackpool had not taken place during the inspection as there were not enough staff to support people.

● We saw some people engaging in art and craft activities. One relative told us this was not usual. "Today is the first-time I've seen activities happening in here and its because you're here". The activities they put up saying they will do, they never do". Another relative told us that their relative's designated 1-1 hours could be used more effectively to provide more stimulation and access to the local community.

● We spoke with the activities coordinator who told us they had a men's group that regularly went to play snooker and pool in the community. We were told that people were involved with baking, pub lunches, play your cards right and art and crafts. Activities were not displayed in a pictorial way that people could understand. We discussed this with the manager who had already identified areas for improvement in the activities team and told us another staff was due to start shortly to help increase the range of activities on offer.

Improving care quality in response to complaints or concerns

● Complaints were not always managed effectively.

● The service had a complaints file. We found some complaints that we had been made aware of prior to

inspection had not been logged and there was no evidence of investigation. We saw that there had been several complaints received since the last inspection, many relating to poor personal care. During the inspection we spoke with one individual's family who were very unhappy with the service and were moving their relative from the service. They told us they as they had raised concerns on a number of occasions with the management team, but felt that they had not received an appropriate resolution. We raised this an immediate concern with the manager who told us he had arranged a meeting with the family, the day before inspection but this had been cancelled as a decision had already been made to move. The manager and deputy manager told us they had not been aware of any concerns previously.

● We looked at how other complaints were managed and found they were not always investigated appropriately, and it was not clear if there was an agreed resolution. We raised this with the manager who could not provide any explanations due to not being in post at the time.

The provider failed to ensure that complaints were managed effectively. This is a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The manager was able to give us an example of one complaint from a relative that he had personally dealt with effectively and responded in accordance with the services policy and procedures.

End of life care and support

● Staff had not completed end of life training. We recommend that the provider source end of life training to ensure that people are afforded dignity and appropriate support at the end of their life.

● There was no one on end of life support at the home but the staff said they had cared for people previously and had received positive feedback. We saw thank you cards from people praising the staff for the care they provided at end of life. One card read, "It's always sad when you a parent dies but the love and comfort you gave us is something we will always remember. "

● Some people's end of life wishes had been recorded and staff were aware of these.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated 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

- The service has been rated as requires improvement for a total of three times. Although the provider generally addressed the issues found at the last inspection, we have identified additional concerns during this inspection. This meant the service has not been consistently well-led and the provider has failed to sustain continuous improvements.
- The current manager was new to the service and told us that he was in the process of applying to be the registered manager. However, this had been the third manager this year and relatives and staff told us that the service had deteriorated. Since the last inspection, there had been an increase in the complexity and numbers of people being supported at Andrew Smith House and this, combined with a clear lack of leadership had contributed to poor outcomes for people at the service.
- Staff meetings were not taking place regularly. We only saw evidence of one team meeting taking place this year in October 2019 since the new manager had been in post.
- Some audits were taking place and the new manager had identified that audits in training, competencies, activities and night observations audits were needed. Quality assurance was not effective enough to identify and monitor the shortfalls in the quality of the service people received. Provider audits were not robust enough to pick up the issues that we found on inspection. Although some issues had been identified, these did not reflect the extent of the concerns and breaches of legislation that we had found during the inspection. In view of the lack of leadership at the service and the concerns that staff were raising to ourselves and safeguarding, a more consistent management oversight of the service was warranted.

Our findings showed governance arrangements had not been robust enough. The provider had failed to ensure systems in place to monitor the quality and safety of the service were operated effectively This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service was not an open culture. Morale was low at the service and several staff were fearful of speaking out. Some staff had expressed concerns about bullying prior to inspection. We looked at how this was managed, and it was unclear of the outcomes. The new manager reassured us that he would take

concerns about bullying seriously and investigate in line with policies and procedures.
● Some staff had whistle-blown about the service as they were concerned about the care people were receiving. They told us that they didn't feel listened too. We saw evidence of staff surveys taking place, but the response rate was poor. The manager agreed to consult with staff and send further questionnaires out in the future to ascertain their views.
● Some relatives told us they felt they were not popular for voicing their concerns. We raised this with the manager who told us he had organised a relatives meeting following our inspection and encouraged people and relatives to raise any concerns.
● The new manager was keen to promote an open culture and although he had not been in post long, feedback about him had been positive. One relative that was happy with the outcome of a complaint wrote, "It's wonderful to have you as the Manager at Andrew Smith and already I can see the improvements you have made."
●We saw evidence of people being involved in the service, newsletters and the service ran an employee of the month award recognising the hard work and achievements of the staff.
● Appropriate policies were in place to ensure people's diverse needs were considered and supported, covering, gender, religion and personal and sexual relationships.

Continuous learning and improving care
● The provider met with us during the inspection and agreed some immediate actions that that they could implement to improve the level of care provided to people. Both the manager and provider were open and honest during the inspection and were keen to work with CQC to improve standards at the service.
● The manager was passionate about raising standards and reassured us that they would take action on the concerns raised during the inspection and learn from previous mistakes. The manager told us that they had a wealth of experience and would continue to keep themselves up to date with developments and research and accessing CQC website to ensure their knowledge base was maintained.

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 providers policies and procedures provided guidance around the duty of candour responsibility if something was to go wrong.
● The manager understood their legal obligations, including conditions of CQC registration and those of other organisations.

Working in partnership with others
● Records and discussion showed the service worked in partnership with a variety of health and social care professionals to ensure people received the support they needed. These included safeguarding officers, social workers, pharmacists and community nurses.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that medicines wee being managed safely. The provider failed to ensure that infection control procedures were in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure that complaints were managed effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that the service was managed effectively,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

	The provider failed to ensure that staff were safely recruited and had a DBS before starting work at the service.
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staffing levels were appropriate and to ensure that they received appropriate training and induction.