Angels (Stratton House) Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Angels (Stratton House) Limited is a nursing home providing personal and nursing care for up to 24 older people, some who are living with dementia. At the time of the inspection there were 21 people living at the service. The service is laid out over two floors that can be accessed by stairs and a lift. There are two communal lounges, a dining room and level access to front gardens.

People's experience of using this service and what we found
Governance systems continued to not be fully effective and meant repeated shortfalls at the service were found in relation to record keeping and risks to people. There was a lack of provider oversight. The service was reliant on the local authority identifying areas of improvement and directing changes.

Improvements had been made to ensure a stable, consistent staff team who knew people well. There was a friendly and positive atmosphere at the service. We received positive feedback about the support people received from staff, who were caring and responsive to people's needs.

Staff now received regular supervision and training. Recruitment procedures were now fully followed. Improvements had been made to the environment and décor. People's rooms were homely. The service was clean and tidy. Infection prevention control measures were in place and adhered to.

Care plans continued to need development to ensure they were person centred and accurate. People's capacity was assessed in relation to specific decisions. However, improvements were needed to ensure capacity assessments and best interest decisions fully followed the Mental Capacity Act 2005 guidance. The recording and management of complaints had improved. However, the provider needed to ensure if complaints were escalated the complaints procedures could be effectively followed.

Medicines were managed safely. People enjoyed the food at the service and different diets were catered for. Activities were provided. We received positive feedback about the registered manager and how the service was being led. Staff were supported.

Accidents and incidents were reported and recorded. Safeguarding systems were in place to protect people from abuse. However, potential safeguarding concerns were not always identified as the records were not followed through.

Communication had improved both internally and externally, which supported lessons being learnt. Regular meetings occurred with staff and comprehensive handover information. Relatives were kept updated and informed. Relatives were involved in reviews of people's care. People, relatives and staff were asked for feedback through surveys.

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.

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 18 May 2022).

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.

At our last inspection we recommended that provider reviewed documentation around consent to specific areas of people's care in line with The Mental Capacity Act 2005 (MCA). At this inspection we found that the provider had met this recommendation but improvements were still needed in fully following MCA guidance.

The service remains rated requires improvement. This service has been rated requires improvement or inadequate for the last four consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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 remained requires improvement.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (Angels) Stratton House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified repeated breaches in relation to Regulations 12 (Safe care and treatment) and 17 (Good Governance).

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Angels (Stratton House) Limited

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 conducted by 2 inspectors and 2 Expert by Experiences. 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
(Angels) Stratton House Limited 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. (Angels) Stratton House Limited 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 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 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. 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 8 people, 3 relatives and 14 staff members which included the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We made observations of the care and support people received. We reviewed 7 people's care records and multiple medicine records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures and audits were reviewed. Afterwards we spoke with a further 15 relatives. We received feedback from 2 health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At previous inspections in May 2021 and April 2022 we identified the provider had failed to manage risks to people effectively. This was a breach of Regulation 12 (Safe Care and Treatment) 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 12.

● Improvements were still required to ensure risks related to people's skin integrity were effectively managed. Whilst wound plans were in place, monitoring improving or deteriorating wounds was difficult due to photographs not regularly being taken and a measuring tool not being used.
● Position change charts continued to not always accurately reflect people's care plan guidance. For example, in one person's care plan, the guidance was, "Two hourly repositioning during the day", but position change charts did not reflect this had been completed.
● Risk assessments for another person who had recently moved to the service had been completed for malnutrition and skin integrity. Despite the person being assessed as high risk, there was no care plan in place to guide staff to minimise the risks identified. Repositioning records for this person did not specify how often the staff should support the person to change position and repositioning charts reviewed showed a differing frequency of position changes.
● Records in place to monitor people's fluid intake were still not always sufficiently completed, this meant it was unclear how concerns about fluid intake were identified and escalated.
● A risk assessment for one person with a urinary catheter described the reasons why the catheter was in place. However, there was no information for staff on how to maintain the catheter, such as how to reduce the risk of infection and blockage.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the registered manager sent us evidence fluid records had been reviewed to ensure accurate fluid targets were recorded and a checklist had been developed to monitor daily records.
● Risk assessments were conducted for people around areas such as mobility, malnutrition and choking. Risk assessments were now updated and reviewed regularly.
● Information was clear around equipment being used, such as hoists, slings and stand aids. We observed

staff supporting people safely, without rushing them from their wheelchair to an armchair. Staff spoke kindly, giving clear instructions and reassured them through the process.
● Guidance from health professionals were now held in the care plan to ensure they were accessible. For example, Speech and Language Therapists (SALT) guidance.
● Information around environmental and health and safety checks were now well organised. Regular checks were conducted. Actions taken in response to a legionella assessment had not been completed. The registered manager sent this after the inspection.
● Regular checks on fire safety systems and equipment were undertaken. A business continuity plan detailed procedures to follow in unforeseen events.

Preventing and controlling infection

At previous inspections in June 2019, May 2021 and April 2022 we identified the provider had failed to manage infection control risks effectively. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of Regulation 12 in relation to infection control risks.

● The service was clean and tidy. Relatives told us, "[Name of relative] has a nice room and it's clean all the time," "The home is clean" and "It's cleaner and brighter."
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits in line with current guidance. Relatives said, "I can visit when I like," and "I am most welcome to visit."

Systems and processes to safeguard people from the risk of abuse
● People and relatives told us they were safe. A person said, "The staff are very good." A relative said, "[Name of person] is well looked after. They have told us they are happy here."
● Staff had completed safeguarding training and knew how to identify and report potential abuse.
● Whilst safeguarding concerns had been reported to the local authority and CQC as required. We found two incidents where unexplained bruising had been identified. This had been documented internally. However, the process had not been fully completed to consider if this required further reporting in line with safeguarding procedures. The registered manager completed this after the inspection.

Learning lessons when things go wrong
● Accidents and incidents were reported and recorded. We reviewed accident and incident forms from

February 2023 to April 2023. Sections on the form such as who the accident/incident had been reported to and the management review had not always been completed. This part of the form prompts if external agencies need notifying and supports in the identification of safeguarding concerns, as described above.
● Despite this, actions had been taken in response to accidents and incidents. For example, by contacting a person's GP.
● Since the last inspection improvements had been made to regularly analyse information regarding accidents and incidents in order to identify patterns and trends and prevent further reoccurrence. For example, a relative told us, "As [name of person's] mobility changed, they moved rooms to make it more suitable for them."
● Improvements had been made since the last inspection in ensuring lessons were learnt from complaints, accidents and incidents and safeguarding. Systems were in place to ensure this information was effectively shared with the staff team. For example, through written handover sheets and a daily meeting. A staff member said, "We are told what we need at the daily flash meeting."

Staffing and recruitment
● Rotas reviewed demonstrated staffing numbers were kept at the level deemed safe by the provider. A staffing dependency tool was used. However, this was being reviewed to ensure it was fully effective due to changes in the staff team and an increase in occupancy in the service.
● We received some mixed feedback about staffing levels. People and relatives told us, "There is enough staff," "There are plenty of staff," and "There are enough staff, seems a lot." Another relative said, "There are probably not enough staff." A staff member said, "Staffing wise, an extra carer is needed."
● Changes in the staff team had meant a stable, structured, consistent staff team were now in place. The home was fully staffed, with minimal use of agency staff. A staff member said, "Staffing is so much better. We work as a team." Another staff member said, "There has been no agency staff for a long time. Has made a difference having familiar staff."
● Improvements had been made in the organisation of recruitment information to ensure the process was fully followed. This included checks on previous employment, right to work and Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines were stored, managed and administered safely. Medicines were administered by staff who had completed training and had their competency assessed.
● The temperature of the clinical room and medicines fridge were monitored. Protocols were in place for people who had 'as required' medicines (PRN) prescribed. Protocols included how people would communicate they required additional medicines.
● Topical medicines such as creams and lotions were administered as prescribed. There was guidance in place directing staff where to apply these.
● Regular medicine audits were carried out. When issues were identified, action plans were put in place. Reports reviewed demonstrated actions identified had been completed.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

At the previous inspection in April 2022, we made a recommendation that the provider reviews documentation around consent to specific areas of people's care in line with The Mental Capacity Act 2005. This had been completed and documentation related to a specific decision. However, we found improvements were still needed to ensure MCA guidance was fully followed.

● People's mental capacity to consent to aspects of their care had been assessed.
However, when best interest decisions were made, the documentation in place lacked information to show how decisions were reached. It was not demonstrated if any other less restrictive options had been considered or what those contributing to the decisions input was.
● Capacity assessments and best interest decisions had been completed for specific areas of care. However, there was a lack of understanding of how to apply the MCA as this process had been applied to areas of care and support that may not be required. For example, a person wearing their glasses.
● Best interest decision documents in people's care plans were decision specific, but the content of the documents was replicated. This did not show a person-centred approach to best interest decision making.
● Consent forms had been signed by relatives when they did not always have the legal authority in place to do so.

● DoLS had been applied for when appropriate. When conditions were attached to an authorisation, these were being met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We received some mixed feedback about people choosing when they would like to do things. For example, a person said. "I get up and go to bed when they [staff] are ready, not when I would like." Another person however said, "I can have a shower whenever I would like." This had been discussed in recent staff meetings to ensure staff facilitated people's choices.
● Staff we spoke with told us they asked people's consent before delivering care. A staff member said, "I ask people for consent." We observed staff asking people what they would like to do and offering people choices.
● People had access to their care records. People could choose what information they consented to share.

Supporting people to eat and drink enough to maintain a balanced diet
● We observed staff supporting people with their meals in line with their care plan guidance. For example, one person was in the correct seating position and with the right food texture as described in their care plan. Some staff fully engaged with people, describing the food and checking the person was enjoying it. Whilst other staff had less interactions. The registered manager and senior staff said less experienced staff were being supported to develop their skills in this area.
● There was management oversight of people's nutritional status. This included a monthly overview of people's malnutrition risk assessment scores and monitoring of weight loss and weight gain. External professional support in relation to nutrition was sought when required. A relative said, "[Name of person] is putting on weight, so I know they are eating well. [Name of person] was losing weight before they went in."
● Catering staff spoke to people and their families about their meal preferences. A person said, "The food is good."
● Information in people's care plans was varied in detail. Some care plans contained thorough details of food and drinks preferences others did not.
● Different diets were catered for and textured meals were well presented. A relative said, "Lunch looks good to me. [Name of person] has a special soft diet and is gluten free." Another relative said, "[Name of person] eats well and they [staff] are brilliant with her diabetes."

Staff support: induction, training, skills and experience
● Improvements had been made to ensure staff were fully supported through appropriate induction, ongoing training and regular supervision.
● New staff completed an induction and completed the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff we spoke with and records confirmed staff had regular training and supervision. Staff commented, "Yes, I have completed all my training," "Supervision is done regularly now" and "Supervision is so supportive."

Adapting service, design, decoration to meet people's needs
● Improvements had been made to the design and décor of the service. Rooms and communal spaces had been decorated and refurbished. A staff member said, "It is more homely. People are more relaxed and comfortable." A relative said, "[Name of person] is happy and likes his room." Another relative said, "[Name of person's] room is nice. It's their own space."
● A refurbishment plan was in place. However, this required further specific detail to ensure improvements

continued and that infection prevention control had been fully considered. For example, in the replacement of flooring.

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

● The service facilitated access to further healthcare when required. A relative said, "They organised her hearing aids as one broke." Another relative said, "They are quick to let me know if she saw a GP or medication changed, all that information is related by phone or email."

Requires Improvement

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 requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The complaints policy was displayed within the service. This detailed how complaints would be escalated within the organisation. However, this was raised with the provider as previously it had been demonstrated that the provider had not followed this process. Assurance was required that the designated person as outlined in the complaints policy could manage complaints effectively.
- The management of complaints by the registered manager had improved. Records showed how these were investigated, responded to and lessons learnt were shared within the service. However, 1 complaint had not fully followed this process.
- People and relatives said they were comfortable raising concerns. A person said, "If I had a concern. I would speak to my husband and then he would speak to the [registered] manager." A relative said, "The registered manager is helpful and listens. I have never complained but have made suggestions."

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

- At our last comprehensive inspection in April 2022 care plans were being reviewed to ensure they were person centred, accurate and detailed. However, with new admissions to the service and staffing changes these developments were ongoing and had not been completed. This meant the quality of care plans varied.

- Some care plans described people's past interests, family and religious needs. For example, one care plan detailed how the person had sung in a choir and parts of the country they had previously resided in.
- Other care plans reviewed were limited in describing people's preferences and choices.
- Care plans identified people's needs but did not always provide enough guidance for staff to be able to support in a person centred way. For example, two care plans we reviewed documented an additional carer may be needed to facilitate support when people were resistant to personal care. However, the care plan did not describe how an additional carer would assist to deliver care in a way people accepted.
- The service was ensuring people and relatives were more involved in reviews of their care. Relatives said, "We had a case review just before Christmas and I feel involved in her care" and "We have regular care reviews."
- Staff were observed to be responsive to people's needs promptly. A relative said, "Staff are so lovely, caring and welcome. Always helping people, they go out of their way."

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

- A range of activities took place and a board displayed what was on offer. For example, arts and craft, singing, dancing, baking and some sensory activities. An external entertainer visited every 3 months. A

person said, "I enjoy singing."
● Staff employed to provide activities was being extended to cover the full week. A relative said, "Staff take them out in the summer, to the local fete for example. A singer comes in. [Name of person] has some 1:1 activity."
● Care plans described people's preferred activities. A relative said, "There is plenty to do. Something on every day, morning and afternoon. Another relative commented, "Sometimes music or other activities but not enough."

End of life care and support
● The service was not currently supporting anyone with end of life care. Staff had received training in end of life care. Some people had their future wishes described. Further work was required to develop this information in people's care plans where people chose.
● A relative commented on the positive end of life care their loved one received at the service, "I would like to express our gratitude for the care [Name of person] received in the last 2 weeks of her life especially."

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.

● Information was displayed in accessible formats such as pictorial signs or in large print. For example, the menu.
● Easy read documentation was being developed to support people further. For example, in gathering feedback from people.
● Care plans in relation to people's communication needs were detailed and included for example, how people wished staff to address them.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At the inspections conducted in June 2019, May 2021 and April 2022 the provider had failed to operate effective governance systems, this was in breach of Regulation 17 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.

- There was no provider oversight of the service. This meant the provider could not be assured if previous breaches in regulation had been met or if further support to implement improvements was needed. This had been raised at previous inspections. After the inspection we were informed changes were being made to ensure provider level oversight of the service.
- The provider had failed to achieve a rating of good overall since their inspection published 23 December 2016. The provider had not been compliant with Regulation 12 and 17 since their inspection published 25 September 2019.
- The provider had a service improvement plan developed in conjunction with the local authority. Many areas of this plan had been achieved in the last 12 months. For example, improving areas such as permanent staffing, staff training, supervision and communication. The improvement plan included areas identified at this inspection. For example, in relation to repositioning records, person centred care planning and fluid records. However, the provider had not identified these areas themselves.
- Whilst some improvements had been made in governance systems since the last inspection in April 2022 as demonstrated in areas such as infection control, recruitment and the environment. Further improvements were needed to ensure governance systems were fully effective in promptly identifying shortfalls in recording. For example, repositioning records, fluid charts, and accidents reports.
- The provider had not ensured planned improvements to care plans had progressed to ensure people's records were person centred, accurate and detailed. Protected time to implement the changes required to care plans had not been planned.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications had been submitted as required. A notification is information about an event or person which the service is required to inform CQC of. However, as detailed in the safe section of this report, potential safeguarding concerns had not always been identified as the accident and incident documentation had not been fully completed to determine if a notification was required.
● The provider had displayed their Care Quality Commission (CQC) assessment rating at the service and on their website, it had previously been highlighted to the provider how to make this more visible. Some information on the providers website had not been updated. The provider said this would be addressed.
● Improvements had been made to ensure an effective staffing structure was in place. Staff were clear of their roles and responsibilities to ensure accountability and efficient communication. Office space and documents had been organised to ensure information was easily located.
● Improvements had been made to ensure there was effective communication and learning from areas such as safeguarding, complaints and accidents and incidents. This included a comprehensive handover document and regular meetings with staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We received positive feedback about the management of the service and the changes they had made. A staff member said, "Management have taken a lot of interest in staff and what is going on. There is an open door policy. I can raise concerns." A relative said, "The registered manager is very approachable." Another relative said, "I think it is well managed, much better than before."
● Relatives commented how staff cared well for people. A relative said, "I have nothing but positive things to say. Staff know [Name of person]. Staff are kind and keep me informed." Another relative said, "[Name of person] is well looked after."
● The culture and atmosphere at the service had improved. A staff member said, "We work as a team." A relative said, "It feels like a family home." Another relative said, "Everything is working well; they are in contact all the time and I have no complaints at all."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their responsibilities under the duty of candour legislation. Communication had improved within the service. A relative said, "They keep me informed and that is important to me." Another relative said, "They always ring me."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● Surveys had now been completed with people, staff and relatives to gain feedback. An action plan was in place to address the points raised. A person said, "I have been asked for feedback, by questionnaires and surveys." A relative said, "We get a questionnaire, and at the annual review I say what I think."
● Regular staff and daily meetings were held. This meant staff had opportunities to raise any concerns and information was effectively shared. A staff member said, "Staff meetings happen."
● A 'resident of the day' system focused daily on one person. This system reviewing their experiences of care in relation to the environment, meals, personal care and activities.

Working in partnership with others
● The provider had been heavily supported by the local authority in implementing improvements in the service. The provider recognised the service needs to be able to identify and make improvements independently.
● The service worked with external health and social care professionals to support people's care needs. For

example, GPs, dental services and social workers.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to manage risks to people effectively. Regulation 12 (1)((2)(a)(b)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality of the service including the mitigation of all risks to people as governance systems were not fully effective. Regulation 17 (1)(2)(a)(b)

The enforcement action we took:

We served a warning notice.