Rapport Housing and Care

Connors House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Connors House is a care home providing personal and nursing care to up to 47 people. The service provides support to older people with varying care needs including, dementia, diabetes and mental health needs. At the time of our inspection there were 38 people using the service. The service was spread across three wings, all ground floor accommodation. Although people living with dementia lived across the service, one wing supported people living with more advanced dementia.

People's experience of using this service and what we found
Although the feedback from people living at Connors House and their relatives was mainly positive, we found the provider had ineffective systems in place to monitor people's safety and well-being. Risks were not always identified and mitigated against. Accidents and incidents were not effectively reviewed and monitored to minimise the risk of them happening again. Medicines were not always managed well. Systems to monitor people's medicines were not robust to pick up issues which meant people may not receive their medicines as required.

Staff did not have comprehensive and accurate guidance around people's care needs as records were not updated regularly and contained information that was not consistent throughout the care plan. The environment did not meet the needs of those living with dementia and some areas of the service were in need of refurbishment.

People were supported to access support and advice from healthcare professionals. However, the outcome of people's medical appointments and advice given was not always used to update care records and not consistently followed by staff. Changes in people's health needs had not always been recorded to give staff clear information about how to support them safely given their changed circumstances. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Systems to monitor the safety and quality of the service people received were not effective. Action plans lacked detail and timescales for completion were not met. Audit systems were not robust and did not identify concerns. The provider did not have adequate management and oversight of the service.

People and their relatives told us they were happy with the support provided. The comments we received included. " Yes, I get the care I need; showering goes smoothly"; " I am confident in the staff they are patient, diligent and supportive" and, "Yes, the permanent staff do know how to support him as they know his issues". People told us the food was good, they had snacks through the day and plenty to drink.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 27 April 2019).

Why we inspected
We received concerns in relation to staffing issues, incidents, complaints and provider management and oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. During the inspection, we found concerns in relation to the MCA 2005, so we also reviewed the key question effective.

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 good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

We stepped back from taking significant enforcement action following this inspection as the provider told us they planned to close this service. The provider has a plan in place with the local authority to find suitable alternative accommodation and care for the people living at Connors House. People are starting to move to their new homes at the time of writing this report. You can see what action we have asked the provider to take at the end of this full report.

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

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

We have identified breaches in relation to effective risk management, medicines management, staffing, person centred care accurate record keeping and management and leadership at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service. We will meet with the provider following this report being published to discuss how they will make sure people receive safe care until they move to their new home. We will work with the local authority to monitor progress.

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

Connors House

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
This inspection was carried out by two inspectors, and an Expert by Experience who made calls to people and relatives. 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
Connors House 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. Connors House 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
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 since the last inspection. We sought feedback from the local authority, including their safeguarding team, and professionals who work with the service. We also sought feedback from the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and twelve relatives about their experience of the care provided. We observed the care provided within the communal areas. We spoke with nine members of staff including the registered manager, deputy manager, senior care workers, care workers and the chef.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at five 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.

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 good. 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; Learning lessons when things go wrong

- The assessment and management of risk was poor. Sufficient information and guidance were not provided to ensure staff knew how to reduce risks when providing people's care. Sufficient guidance was not in place for staff to make sure people with insulin dependent diabetes were supported safely. One person had no care plan or risk assessment in place specific to their diabetes. Signs of high or low blood sugar levels for the person were therefore not recorded. This meant new or agency staff may not have the information they needed to spot early signs and prevent a potentially life-threatening diabetic event.
- One person was known to have epileptic seizures. Risks had not been identified to keep the person safe in the event of a seizure. Specific guidance was not available for staff on how to ensure the person's safety when they were bathing, such as never being left alone while in the bath to prevent the risk of drowning. The person had been known to have a seizure while in the bath. Staff were present at that time, so the person did not come to any harm. However, some staff, for example, new or agency staff, may not understand the life-threatening risks of the person being left alone in the bath for any length of time.
- Risks around loss of weight and choking had not been mitigated. One person had lost weight and their care plan advised staff to weigh the person weekly. There was only one record of the person having been weighed, on 4 August 2022, three weeks after the care plan was written, and not since. One person had experienced swallowing difficulties. Although a referral had been made to the dietician, staff had not followed their initial advice, to keep a diary to inform their assessment when they visited. The diary had been completed sporadically, with many days between recordings. A risk assessment was not in place to mitigate against the risks of choking. This meant people were at risk of not receiving safe care.
- Two people were identified as being at risk of suicide or self-harm. One person had previously attempted suicide and another person had been heard by staff saying they wanted to commit suicide. Although both people had accessed the community mental health team, a specific risk assessment was not in place to provide guidance to staff and to mitigate against risks, placing them at risk of harm.
- Accidents and incidents such as falls were not sufficiently assessed to provide guidance to staff to prevent further falls. One person had Parkinson's disease, and this had not been identified as a risk factor in their care plan. The person was assessed as being at high risk of falls. A falls risk assessment tool, following their admission in June 2022, identified the need for a falls risk assessment protocol and a falls prevention plan to be completed. Neither of these were in place. The person had fallen twice since June 2022, receiving minor injuries.
- The management and oversight of incidents and accidents was poor and had not been used as an opportunity for learning lessons to mitigate future risks. Action had not been taken to minimise the risks of similar incidents occurring to people through regular review and close monitoring.

Using medicines safely

● Medicines were not managed safely. Some people needed medicines on a 'as and when' basis, for example pain relief. We found there was not always guidance for staff to follow, to check if the medicine was effective, or to make sure the maximum dose of the medicine in a 24-hour period was not exceeded. This had been identified through two of the provider's own audits, but action had not been taken to rectify the issue. This increased the risk people might not receive their medicines when they needed them or according to the prescribing guidance.
● Where staff had handwritten a medicine onto the medicines administration record (MAR), for example, for a medicine that was prescribed part way through the month's cycle, these were not double signed by staff, in line with NICE guidance, 'Managing Medicines in Care Homes'. This meant checks were not in place to make sure the handwritten entry was exactly as written by the health care professional who prescribed the medicine.
● Senior care staff administered medicines. The senior care staff made regular counts of medicines in stock and compared this with the medicines that had been given to check accuracy. No other counts were completed by the management team or the provider to ensure medicines were being administered safely and no medicines were unaccounted for. One person's medicine had one tablet less than there should have been according to the MAR, when we did a random check. This had not been identified and meant the person may have missed one of their medicines.
● Assessments to check the competency of staff who administered people's medicines had not been completed regularly. One member of staff told us they had not had a competency assessment since 2017 until July 2022, even though they administered people's medicines. Staff were administering insulin to people by injection. Staff had been trained in 2018, however, this had not been refreshed, or form part of a regular competency assessment. We could not be assured staff had continued to use safe practice when administering people's medicines.
● Some people did not have care plans and risk assessments in relation to their prescribed medicines. One person's medication care plan and their pain care plan were blank. The person was admitted to the service in July 2022. This meant they may not receive care that met their needs and preferences or that was safe.

The registered person failed to assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. The registered person failed to manage medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Insufficient numbers of suitably skilled staff were deployed at times to deliver people's care. Senior care staff and some carers were trained to administer medicines. No senior staff were available on night duty, only one 'lead carer', who was trained to administer medicines. On the nights the lead carer was not on duty, there were often nights with no staff trained to administer medicines overnight. The registered manager told us they or the deputy manager would attend during the night to administer medicines such as painkillers or calming medicine if it was needed. They told us they had never been called out. However, one member of staff told us they had arrived early morning on more than one occasion and needed to give people painkillers straight away as they had been asking for them, but trained staff were not available.
● Senior care staff on day duty were expected by the provider to start their duty early in the morning before their shift started, and stay late in the evening after their shift ended, to administer medicines when senior night staff were not available. The registered manager and senior care staff confirmed this. The registered manager and the provider told us after the inspection they would be training more care staff to administer medicines. However, this was not considered until after our inspection.
● People's dependency needs were assessed to determine if they had high, medium or low needs. However, the individual assessments were not used to identify the numbers of staff required on duty to meet people's needs at any given time. The registered manager told us staffing levels remained the same and this worked

well. However, staff told us the numbers of staff didn't change, irrespective of the numbers of people living in the service and their specific needs. One member of staff said, "No, staff numbers are always the same, they don't change depending on who is living here". This meant staff may not always be able to meet people's needs if many people with high needs are living at the service at the same time.

● There were staff shortages, resulting in high numbers of agency staff being used to make up numbers. Permanent staff felt this was an added burden, even though most agency staff worked well and provided good care. Staff needed to induct new agency staff and were never sure they would return. The information the provider needed to have in place about individual agency staff, such as their training records and safety checks such as DBS and references were not all recorded on file. Some agency staff's induction records for Connors House were not recorded.

The registered person failed to provide enough suitably qualified staff. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● People and their relatives told us there were usually enough staff on duty, although there were often a number of agency staff on shift. The provider told us they were struggling to recruit staff and were constantly advertising for staff.

● The provider recruited new staff safely. New staff completed an application form with a full employment history, suitable references were followed up and identity checks made. Disclosure and Barring Service (DBS) checks were made. This provided information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● There were systems and processes in place to support people from the risk of abuse. Staff received training in safeguarding, and staff we spoke with had a good understanding of the types of abuse, and how and where to escalate concerns.

● People and their loved ones felt they were safe at Connors House. Comments included, "Yes, safe, and happy, all good"; "I would speak to the head carer/manager if any concerns" and "I would talk to anybody on duty when I phone or visit."

● The registered manager understood their responsibilities to report concerns to the local safeguarding authority. They had raised concerns and worked with the local authority by providing information requested, supporting investigations.

Preventing and controlling infection

● 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

People were able to have visitors when they chose. People and relatives told us they visited regularly.

Peoples relatives were visiting at different times of the day during the inspection.

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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's care plans and risk assessments did not always provide the detail needed to provide support that was individual and met their needs. Although assessments were completed before people moved into Connors House, the information about their needs and preferences were not always fully assessed and developed into a care plan. People's care plans were not always updated to make sure their current needs were met.
- One person's care record in relation to, 'what you need to know about me' was blank with a note attached in March 2021 saying the person had declined to talk about this. No record was made if this had been reviewed, or staff had tried to speak to the person or their relative since then to gather the information. Another person's care plan was incomplete with blank sections where personal history and important personal information should have been recorded.
- Some people were living with dementia and became anxious due to confusion and their surroundings. Staff recorded episodes of anxiety on a form, meant to record what happened before the incident, and what happened during and after the incident. Staff did not use the record in the way it was intended and were not respectful in the way they recorded episodes of increased anxiety. We reviewed five incidents recorded on one person's forms between June and August 2022. The description on the forms included, 'behaviour is very selective and (they) choose when to cooperate'. However, the person's care plan described the person was 'lovely' and 'speaks very quietly'. There was no indication in the person's care plan or risk assessments that they had incidents of raised anxiety and no guidance to make sure they received positive and consistent support before, during and after these episodes.
- People's needs were assessed using recognised tools, including skin integrity, nutritional needs and falls, however these were not always completed fully or correctly. This meant the assessment of risk in these areas may not be identified appropriately and people may not be supported in a way that met their needs and preferences. One person, who was at risk of malnutrition as they had lost weight and had swallowing difficulties, had a nutritional assessment not fully completed. The record stated 'unknown' in two areas, which resulted in a 0 score for each. This meant the total score and therefore assessment of risk was not correct, putting the person at risk of harm.

The registered person failed to ensure care and treatment was appropriate, met people's needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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.

● Staff had a basic understanding of the MCA and could describe the basic principles they would use on a day to day basis. However, how people's rights were maintained was not always in line with the MCA.
● Some people had been assessed as not having the capacity to consent to living at Connors House and a capacity assessment had been completed. However, the assessments did not always clearly record why the assessor had made the decision the person lacked capacity. The reason given on one person's capacity assessment was that they were unable to remember the door key code. There was no record the person had been assessed at another time of the day, or by using a different method other than memorising a set of numbers. People were not assessed at differing times or by using various methods that could support their decision making when staff assessed their capacity to consent.
● Capacity assessments had not always been followed by a best interest decision-making process to evidence decisions made on people's behalf were in their best interests and the least restrictive option. Relevant people such as loved ones were not always involved in best interest decisions to give their perspective. For example, on how the person themselves may have made a decision in the past.
● Mental capacity assessments were not always consistent. One person was assessed as having the capacity to consent to their care and treatment and for all other decisions they had been assessed for but were deemed as not having the capacity to view their care records. A clear record of why this capacity assessment had a different outcome had not been recorded, which meant the person's rights may have not been upheld.
● There was confusion in some people's care records about who signed consent forms. One person had signed some consent forms and a family member had signed other consent forms without an explanation why. The relative did not have the authority through a lasting power of attorney for health and welfare decisions to sign consent.

The registered person failed to put in to practice the requirements of the MCA, this is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Some staff had not updated their training which meant they may not have the most up to date information to make sure they have the appropriate skills to carry out their role.
● Out of the 24 courses completed by staff, 14 courses had an update completion rate of less than 70% of the staff team. These included important training such as safeguarding vulnerable adults, fire awareness, basic first aid and health and safety. Connors House supported a number of people living with dementia who may have anxious periods that affected their life and those around them. Only 57% of staff had updated their positive behaviour support training at the recommended interval. This may affect their ability and skills

in supporting people consistently and effectively. This is an area for improvement.

● Staff had received one to one supervision to discuss their ability in their role and discuss areas for improvement and personal development. Staff told us they felt supported and were happy with the opportunities given to develop.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. 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

- The management, leadership and oversight of the service was ineffective, leading to a deterioration in safety and quality. Although some audits were completed, none were regularly carried out and those that were had not been followed up in order to take action where issues had been identified. One person's care plan record had been audited in August 2022. The audit identified that some care plans were missing and needed urgent action. We reviewed the person's records and found the same care plans outstanding and had not been re-checked to make sure action had been taken. Monthly medicines audits did not identify which medicines records were looked at and did not identify the issues we found.
- The provider carried out limited checks to make sure care provided was safe and of good quality. We found that care was not safe, and people were not always provided with care that was of good quality. Significant concerns in relation to people's safety, the care people received, and guidance provided to staff were identified during this inspection.
- Staff told us the provider's senior managers visited infrequently and when they did visit, they did not complete checks, but sat and did their work in the office. There was no evidence senior managers walked around the service to speak to people, make checks or observations of safety and quality or carry out audits. There were limited audits or monitoring activity in the service by the provider's representatives. A consultant had completed an audit on 10 August 22. Many of the actions needed to make improvement had not been completed. The provider had not taken action to make sure recommended actions were completed. We found the same concerns highlighted in the consultant audit were evident throughout our inspection.
- We found many areas of concern during the inspection and these had not been identified by the provider. Care plans and risk assessments did not provide sufficient information about people to make sure they received good care that was safe and individual. Care records had not been checked. People who were meant to have their weight checked weekly or monthly were not consistently supported with this. Staff had not recorded in people's bowel charts regularly. One person's bowel chart had three separate gaps over the period of one month, of 10 days, nine days and eight days. The provider and management team could not be assured whether the person had their bowels opened or not and if healthcare intervention needed to be sought, due to inaccurate record keeping. Action had not been taken to address this.
- The oversight of accidents and incidents by the provider was ineffective. Incidents such as when people had episodes of anxiety or falls had not been monitored, by the service management team or by the provider. This meant themes, or ways to prevent future occurrences had not been explored.
- Accident and incident records were chaotic. Individual records were not kept within people's individual care files. The registered manager told us some records were on the senior care staff's desk awaiting action,

some were on the deputy managers desk awaiting their action. Following the deputy manager's review, the records went into the admin office to be entered onto a log then filed away. Immediate action required and immediate themes may be missed as many incident records were waiting to be reviewed and in a backlog. A clear monitoring system was not in place to make sure people were kept safe from further incidents of harm.
● We found many areas of serious concern during inspections at the provider's other locations between July 2022 and this inspection lessons had not been learnt and shared to improve quality and safety. We found similar concerns at this inspection. One member of staff told us they had read of the issues found at one location in the local newspaper and was shocked, but did not know about concerns found in other locations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Care records did not provide the detail required to ensure people received care that took into account their individual needs and wishes and provide guidance to deliver consistency and respect. Specific forms were in place for staff to record when people had episodes of heightened anxiety. Staff did not use the record as intended, to identify possible reasons, triggers and themes for people's anxiety. Staff did not complete the whole document, writing across the record and not following the instructions and columns to complete. This meant signs of increasing anxiety or what worked well to lessen anxiety could not be picked up through monitoring to make sure people received individual, positive support .
● Individual tracking forms, to enable monitoring of incidents of people's anxiety, had not been completed. One person had a number of incidents of heightened anxiety recorded. However, the tracking form recorded only one incident. This shortfall had not been picked up by the management team. People's records in relation to raised anxiety were not accurate, there was no evidence they were used for monitoring purposes to review and update care plans and risk assessments. This meant people may not receive individual and appropriate care that specifically met their needs
● We received mixed feedback from staff. Some staff said they felt the stress of an increased number of agency staff as this added to their workload. Some senior care staff told us the amount of responsibilities they had during a shift was not always manageable. Only one senior carer was on duty for each shift. Staff told us administering medicines alone during the morning shift could take two to three hours. The registered manager told us a carer trained to administer medicines sometimes helped, but staff told us this did not happen regularly and was not additional staff, it meant a carer was taken off caring duties with no replacement.
● Some staff told us the registered manager and deputy manager spent a lot of time in the office and were not often seen around the service. However, staff did find the management team approachable and were confident they would take action when issues were raised.

The registered person failed to operate a robust quality assurance process to continually understand and have oversight of the quality of the service and ensure any shortfalls were addressed. The registered person failed to maintain accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from people and relatives was mainly good, relatives knew the management team and most, but not all, said they were happy to raise concerns. The comments we received included, "They are all nice people here - I like it here - I feel comfortable. I'm happy here – no concerns" and "Yes, it is well managed, and we can speak to the manager" and, "I don't always feel listened to, concerns are not always taken well".

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

characteristics; Working in partnership with others

● We reviewed the providers response to complaints and found a positive approach was not always taken by the management team to some complaints raised. An objective assessment with a view to learning lessons and improve the service provided was not evident.

● The provider supported people to engage in the service by holding meetings with people. One person told us, "We have resident meetings, they are useful". Relatives meetings were not held as regularly but all the relatives we spoke with told us a meeting was arranged for the following week that they planned to attend. Most relatives said they were happy with the level of engagement and felt they were listened to.

● The registered manager held staff meetings fairly regularly. Staff said they felt able to raise concerns or ideas during staff meetings. Staff told us they did not feel supported by the provider and senior management team as they did not engage with them or visit the service regularly.

● People were referred to health care professionals and the service had close working relationships.

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 duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. We found that the registered manager had been open and honest, and understood their responsibility to comply with the duty of candour.

● When incidents occurred, incident documentation reminded staff to apologise to people and their loved ones.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and treatment was appropriate, met people's needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to put in to practice the requirements of the MCA.

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 assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. The provider failed to manage medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate a robust quality assurance process to continually understand and have oversight of the quality of the service and ensure any shortfalls were addressed. The provider failed to maintain accurate and complete records in relation to the service and

people's care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to provide enough suitably qualified staff.