Bramley Court Care Homes Limited

Bramley Court Care Home

Inspection report

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Birmingham
West Midlands
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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 caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bramley Court Care Home is a care home providing personal and nursing care to up to 76 people. It specialises in working with older people and people living with dementia. At the time of our inspection there were 73 people living at the home. The home is divided into four separate smaller homes within the building, each has its own lounge and dining areas and access to a garden area.

People's experience of using this service and what we found
Guidance and training for staff for the use of low-level restraint for people was limited. This meant there was a risk people could be subject to unnecessary or inconsistent use of restraint. Relatives whose loved ones were sometimes supported with low level restraint told us they felt it was used in a safe and proportionate way and we did not see any evidence that people had been harmed.
People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Relatives told us they felt happy with the care their loved ones received and that people were safe. One relative said; "We appreciate that their priority is to care for people and keep them safe."
We found improvement was needed to some aspects of risk management to reduce COVID-19 transmission risk. Relatives told us they were happy with safety checks to ensure visiting was managed safely and they felt the home was very clean. One relative told us; "There are no smells there, no concerns, it is spotless." People were supported by sufficient numbers of staff.

Relatives told us and we saw staff were caring and kind to people. One relative said; "I would never move [my loved one] from here, she has wonderful care."

People's care plans were person centred and tailored to their needs. People were encouraged to take part in a wide range of hobbies and interests. Relatives told us they were impressed with the range of opportunities for people and told us they were consulted about what their loved ones enjoyed doing. One relative said; "They asked me what her hobbies were and what music she likes." People were supported in a variety of ways to stay in contact with their loved ones during the pandemic.
Relatives and staff spoke highly of the registered manager and the management team. They told us the registered manager was supportive and easy to contact if needed. One relative told us; "If I had any concerns I would speak to the manager, she is very good."

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 under the previous provider Zest Care Homes Limited was good (report

published 1 June 2019).

Why we inspected
This was the first inspection under the new provider name Bramley Court Care Homes Limited. The inspection was promoted in part due to concerns received about safeguarding issues. A decision was made for us to inspect and examine those risks.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe monitoring and appropriate training for the use of low-level restraint and insufficient risk management and assessment of COVID-19 transmission risk at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was 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.

Bramley Court Care Home

Detailed findings

Background to this inspection

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

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 completed by two inspectors, a nurse specialist advisor and an assistant inspector.

Service and service type
Bramley Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 04 November 2021 and ended on 15 November 2021.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do

well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and six relatives about their experience of the care provided. We spoke with 15 members of staff including the registered manager, deputy manager, nurses, care workers, the chef, kitchen and domestic staff. 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. 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found, for example details of how use of physical restraint was recorded. We looked at training data and quality assurance records. We contacted two professionals who regularly work with the service.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

- Systems to monitor the use of low-level restraint were not robust. Care notes did not record detailed information about each episode of restraint.
- Case notes were not monitored to ensure the use of restraint was effective and approached in a consistent way by staff. This meant people were at risk of being restrained unnecessarily. Episodes of restraint weren't analysed. Analysis would help staff develop a clear strategy of how to minimise the use of restraint where possible.
- Staff we spoke with lacked clear understanding of restraint and told us the home had a 'no restraint policy'. Staff didn't have a good understanding about what restraint could mean for people or how best to support them safely whilst using restraint.
- Staff hadn't had specific training in the use of low-level restraint by a certified trainer. This could have improved understanding and practice, resulting in more consistent use of restraint practices.
- A best interest's decision hadn't been documented for a person lacking capacity to consent or refuse personal care. This would ensure the ongoing use of restraint was agreed as proportionate and appropriate in some circumstances. Decisions to use restraint were not supported by the knowledge and expertise of others who could speak on the person's behalf.
- A deprivation of liberty (DoLS) application had been made for a person which didn't include information about the use of restraint. This meant the application lacked the information needed to decide about how urgent the need was for assessment. The DoLS assessment was still waiting to be completed at the time of the inspection.
- Peoples' care plans and risk assessments didn't contain guidance about what could trigger the need for restraint. Staff did not have guidance on what steps could be taken to avoid the need for restraint. This meant people may not be supported consistently and safely with use of restraint. This put people at unnecessary risk.

We found no evidence that people had been harmed as a direct result of the use of restraint, however, people were put at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager who agreed to arrange accredited training for staff. They gave assurance they would work on improvements to the recording and analysis of the use of low-level restraint and update the DoLS application to contain information about the use of restraint. Specific guidance in a care plan was updated to give detailed information to staff about the safe and appropriate use of restraint.

● Care plans didn't contain individual COVID-19 risk assessments. This meant action hadn't been taken to consider and reduce risks for people who could be at higher risk from COVID-19.
We spoke with the registered manager who agreed to put in place individual risk assessments for each person living at Bramley Court to consider their individual COVID-19 risks.
● Staff showed good understanding of how to prevent or manage risks people might face. For example, a staff member described how they would prevent disagreements from escalating to keep people safe.
● Regular checks were completed to help ensure the safety of the home and people's care. In relation to fire safety, personal emergency evacuation plans were in place to help staff evacuate people in the event of a fire.

Staffing and recruitment
● Staff and relatives spoken with told us there were enough staff on duty at Bramley Court.
● Staff were visibly present in lounge and dining areas and were available to respond quickly to any requests from people.
● Checks were completed on the suitability of potential staff. These included obtaining previous employment references and checks with the Disclosure and Barring Service (DBS).
● After recruitment staff completed an induction to ensure they had the support skills and information needed to care for people. Shadowing more experienced staff was included in the induction.

Using medicines safely
● People were supported to take homely remedies safely. However, homely remedies were not removed from medicine lists when they became prescribed regularly. We didn't see evidence of unsafe administration of homely remedies, but this was discussed with the registered manager who agreed to review this.
● Care plans included details of medicines people needed and the support they needed with them.
● Nurses and some care staff (care home assistant practitioners- CHAPS) were trained to administer medicines. Once staff had completed training, competency checks were made to ensure continued safe practice.
● Checks were made regularly to ensure medicines were documented clearly and accurately on the medicine administration (MAR) sheets. Where discrepancies occurred, these were investigated.

Preventing and controlling infection
● We were somewhat assured that the provider was accessing testing for people using the service and staff. Staff were completing Polymerase Chain Reaction (PCR) testing in line with government guidance. The results of the tests were monitored. Although staff reported completing Lateral Flow Device (LFD) testing, the results were not recorded and monitored. This meant the registered manager could not be assured that all LFD testing was completed in line with government guidance.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. The infection prevention control policy had not been updated to reflect government guidance on visiting to the home. However, in practice we saw people were supported to receive visitors in line with government guidance and relatives confirmed this. One relative told us; "They have everything in place, they check the LFD test, we wash our hands and they give us PPE."

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. People did not have risk assessments to consider their individual risk from COVID-19. This information would improve the safe and effective management of outbreaks in the home. The registered manager assured us individual COVID-19 risk assessments for people and staff who were at particular risk would be completed.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● 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 promoting safety through the layout and hygiene practices of the premises.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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

Learning lessons when things go wrong
● There were systems in place to record, investigate and learn from incidents and accidents in the home.
● Staff told us they felt comfortable to share information about near misses and incidents and understood these were learning opportunities.
● CCTV was in place in communal areas of the home. The registered manager described ways in which this was used to analyse accidents and incidents. This helped ensure accurate information was used to decide what had happened and how future accidents and incidents could be prevented.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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 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.

- We saw consent being sought during inspection. However, a best interest's decision had not been documented regarding the use of restraint. A DoLS application had been made but did not include the use of restraint for the person. This meant the application didn't contain all information needed to decide on the urgency of the need for assessment. The registered manager took steps to update the application.
- People's care plans guided staff to seek consent before support was offered, we saw this in practice during our visit.
- Some relatives had power of attorney (POA) for a loved one to help make decisions when they lacked capacity to do so. Documentation to evidence this was checked and noted in their care record. This enabled people to be supported in decision making by a relative of their choice.

Staff support: induction, training, skills and experience

- Staff had received some MCA (Mental Capacity Act) training. They had not received accredited training to support people with low level restraint when needed in line with guidance. This meant people were at risk of inconsistent or unsafe restraint practices. The registered manager gave assurance that suitable training would be arranged.
- Staff received regular supervision in line with the service's policy. They told us they felt supported by the management team during the pandemic. One staff member told us; In particular the manager is so

supportive, all through the pandemic they have really been checking in to see if we were ok. "
● After induction care staff who hadn't completed the care certificate were asked to do so as part of their probationary period. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours for carers.
● Staff were knowledgeable about the people they were supporting. They described ways in which they'd learned about people's support needs and built relationships with them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care plans contained information about their life, medical history and healthcare needs as well as their desired outcomes. For example, a care plan detailed how staff could support someone who could become disorientated in the night. This was designed to help the person feel more settled and relaxed.
●The management team obtained information from people, their relatives and the relevant agencies involved in supporting them. This helped them to learn about people's care and support needs.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff prepared foods people liked, to help them eat well. A relative told us; "[My relative] loves her food and eats well." Another told us about when they joined their loved one for a meal; "Dinner was amazing, it was so delicious."
● Staff understood people's dietary needs and prepared meals which reflected this.
● We observed the lunchtime meal service and people were unhurried and able to eat at their own pace. Staff were respectful when supporting people who needed help to eat their meal.

Adapting service, design, decoration to meet people's needs
● The layout of the home provided choice for people about how to spend their time. As well as their own bedrooms, there were shared lounge and dining areas. A garden and an outdoor building could be adapted for particular events and occasions.
● The home was decorated throughout with stimulating colours and pictures. Improvements had been made including the purchase of new washing machines to improve the quality of the laundry service.
● The registered manager oversaw a redecoration programme for the home. This was reviewed every three months and had included redecoration of shared areas of the home and people's bedrooms.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's records contained up to date information about their healthcare and support needs. They included guidance for staff on signs and symptoms to look out for. Staff knew about people's health needs and told us how they supported people to remain healthy.
● People had basic checks to their health on a regular basis. These included pulse, blood pressure and oxygen saturation levels to proactively monitor for any health concerns.
● Emergency care plan records were prepared to help share essential information about peoples' care needs with other healthcare services.
● Staff worked with healthcare professionals involved in people's care and followed their recommendations. This helped people achieve positive outcomes with their healthcare needs.

Good

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 now remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Relatives told us the staff team were caring towards their loved ones. One relative told us; "[The staff] are very good, they are very very caring, it's not just a job it's a vocation and they really do care." We saw staff were polite, patient and respectful with people.
- People's care plans included information about their lifestyle, background and identity. This helped staff get to know them. Staff had completed equality and diversity training and understood the importance of respect.
- Some people living at Bramley court were living with dementia. This could mean a person could experience distress or confusion which could create risk to themselves and to others. Staff we spoke with were able to describe their knowledge and skills. They gave examples of how they would support a person who was distressed.

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

- Relatives told us staff supported people to express their views and make decisions about their care. One relative told us they were consulted about their loved ones likes and dislikes and said; [Their wishes] were respected from the beginning."
- People's care plans included details of how they liked to be communicated with. This included examples of what was and was not helpful. For example, guidance on using very simple clear language and giving people extra time to consider and respond. This supported staff to enhance their communication with people.

Respecting and promoting people's privacy, dignity and independence

- People living in the home looked cared for, they were appropriately dressed and well groomed. One relative told us; "[They] were always clean shaven and wearing clean clothes." Another relative said; "[They] always look clean and tidy and well cared for."
- People's care plans detailed what people may be able to do for themselves. Staff were guided to encourage people to be independent with whatever personal care they could. It was recognised that what people could do for themselves could vary from day to day.

Good

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 good. At this inspection this key question has now remained the same. This meant people's needs were met through good organisation and delivery.

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

● Care plans contained information about people's specific health conditions and detailed information staff needed to keep people safe. However, they lacked guidance for staff on how to support people with the use of low-level restraint. Care plans and risk assessments were reviewed regularly to ensure they reflected people's changing needs. The reviews had not noted the lack of guidance in this area. The registered manager took action to update the guidance during the inspection.

● People and relatives told us they were happy with the care they received. One relative told us; "[My loved one] considers it to be home, we have been really impressed with the care [they] receive, they are doing a sterling job." Another relative said; "We know [they] are safe and well cared for, you can't put a price on that."

● People received the care and support they required. Their care plans included detailed information for staff to support them to do this.

● Care plans were written in person centred language and prompted staff to seek consent before offering any support. We saw staff seeking consent from people and respecting their wishes consistently during our visit.

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 provider had met this standard. Information was provided in a variety of ways to support people to understand. This included the use of picture cards, signage and images around the home.

● People's care plans included information about their ability to communicate and how best to support them with this.

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's hobbies and interests were detailed in their care plans. There were staff dedicated to spending time with people to help them engage in hobbies and pastimes. If people wanted time alone and wanted to stay in their rooms, this was respected.

● A programme of events was advertised throughout the home. We saw people taking part in making candle holders to celebrate the festival of Diwali. People engaged with this and enjoyed it.

● Relatives told us people had plenty of support to engage in hobbies and interests. One relative told us about how their loved one was supported to watch a sport they loved on TV regularly. Another relative said;

"[my loved one] has engaged in some events here, the activity coordinator is lovely."

● People were supported to remain in contact with their relatives during lockdown in various ways. These included by window visit, telephone calls and facetime calls, this lessoned the isolation for people. Relatives were also sent a monthly newsletter. With consent, this could include pictures of their loved ones participating in events. All the relatives we spoke with told us they valued the newsletter. One relative told us; "They send a newsletter with which they make lots of effort, and it's really good to see what they were doing and the breadth of what they were doing."

Improving care quality in response to complaints or concerns

● The service provided information to people and their relatives about how to make a complaint. Complaints, concerns and comments were used to learn and improve the service.

● People and relatives told us if they had any concerns about the service, they would tell staff. One relative told us; "I would normally speak to the manager…. If it was a medical concern, I would speak to one of the nurses, they are lovely."

End of life care and support

● Information about people's last wishes were recorded. Staff knew what to do when people were approaching the end of their life.

● Staff had received training in end of life care. This helped ensure they had the knowledge needed to deliver high quality care to people nearing the end of their lives.

● Relatives told us visiting arrangements had been very flexible. This allowed them to spend as much time as they could with people receiving end of life care.

● Staff prepared a memory book for the relatives of a person after their death. This included lots of photographs of them during their time at Bramley Court. It also contained a personal message/ memory from each staff member they had worked with.

● A professional who works regularly with the service told us; "I always get very positive feedback from families who have received end of life care."

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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

- The provider and registered manager had failed to identify that monitoring of staff testing for COVID-19 was not robust. Staff were completing Polymerase Chain Reaction (PCR) testing in line with government guidance. However Lateral Flow Device (LFD) test results were not being recorded. Staff we spoke with told us they were using LFD testing in line with current government guidance. The registered manager was not able to verify this. This put people at unnecessary risk.
- The provider and registered manager had not ensured people's individual risk from COVID-19 were considered in line with government guidance. People's risk assessments didn't include consideration of how their individual healthcare needs could be impacted by contracting COVID-19. This meant people's care may not have been tailored to their specific needs in the event of a COVID-19 outbreak.
- A COVID-19 risk assessment for staff had was in place. The provider and registered manager hadn't ensured it was updated in line with government guidance. The risk assessment highlighted the need for some staff to have individual risk assessments. It had not identified correctly the higher risk groups that government guidelines reference. Staff who needed to shield were supported to do so. However, we spoke with a number of staff about their own risks from COVID-19. None said they had private discussions about factors which could place them at higher risk from COVID-19.
- Staff had 'breakaway training' to help them protect themselves and others. They had not had training to support people with low level restraint. This training should be accredited in line with government guidance. Training was not sufficient to ensure consistent and safe use of restraint. The provider and registered manager had not recognised this.
- The provider and registered manager hadn't ensured recording and analysis of use of restraint was completed in line with government guidance. Oversight wasn't maintained to ensure the use of restraint remained a consistent last resort and was in people's best interests.

The provider's governance systems were not always effective in identifying the need for improvement in assessing and mitigating risk. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager acted quickly. A monitoring system for staff LFD testing was put in place. They gave assurance the COVID-19 risk assessment would be updated to reflect government guidance. They also advised that risk assessments would be completed for all people and staff who required them.

● Relatives and staff spoke positively about the registered manager. One relative told us; "[The registered manager] is very good, she knows her stuff, and is very much a leader." A staff member told us; "We have a lot of support from the deputy and the manager."

Continuous learning and improving care; Working in partnership with others
● The registered manager had not kept up to date with guidance in some areas. These were the use of restraint, and some aspects of infection prevention guidance. This meant staff were not supported to learn and improve in these areas. There was a risk care was not always optimal for people.
● Staff said they were supported to continue to learn in many areas of their role and to develop professionally.
● The service worked in partnership with health and social care agencies in a timely manner to produce good outcomes for people. People were supported by external professionals including, GPs, Speech and Language Therapists, District Nurses and Occupational Therapists.
● Relevant referrals had been made appropriately and staff knew how to access support for people. For example, the district nursing team had been consulted regarding concerns about a person's skin integrity.
● A health professional who worked regularly with the service told us; "They raise things in a timely manner, they are very responsive, I am very impressed and glad to be working with them."

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 with regard to duty of candour. A duty of candour incident is where an unexpected or unintended incident occurs which results in the death of a person using the service, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and must apologise for the incident.
● The duty of candour was considered for incidents, accidents, complaints and safeguarding matters. We saw written examples of where the duty of candour had been applied and how the service had responded.

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 promoted a positive and inclusive culture for people and their relatives. People were given the opportunity to express their views in meetings and during discussion. Changes were made as a result of these discussions. One relative described how a television in one shared lounge was designated at times for specific sporting events. This ensured people who especially enjoyed them were able to watch them together. The suggestion was from a someone who could watch the events in their own room. However, they enjoyed the company of others with a shared interest.
● Relatives told us they were involved in their loved one's care. They were kept up to date with changes for people or to the service. One relative told us; "We have worked in partnership with them which is ideal."
● Staff told us they took part in regular meetings and felt if they made suggestions they would be listened to.

● People's diversity and equality characteristics were upheld and respected. Care plans detailed how people liked to express their gender identity including details about how they liked to be supported to dress.

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 12 HSCA RA Regulations 2014 Safe care and treatment Staff training and guidance for the use of restraint was not sufficient to ensure it was used safely and consistently and a best interests decision had not been made regarding the possible need for restraint.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality and safety assurance systems had failed to identify that risks to staff and people from COVID-19 had not been fully explored and mitigated.

The enforcement action we took:

A warning notice was served.