Amore Elderly Care Limited

Cooper House Care Home

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

Summary of findings

Overall summary

About the service
Cooper House is a residential care home providing personal and nursing care for up to 80 people aged 65 and over, some of whom are living with dementia. The home is purpose built with accommodation provided in separate units over three floors, each with their own facilities. At the time of our inspection there were 67 people using the service.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks. Safeguarding procedures were not followed consistently.

Parts of the premises were not clean or well maintained. Some people's rooms were personalised and comfortably furnished; others were stark and bare with damaged furniture and no personal effects. Infection control procedures were not always followed by staff as personal protective equipment (PPE) was not worn correctly and social distancing was not maintained.

There were not always enough suitably qualified, competent, skilled and experienced staff deployed to meet people's needs and keep them safe. Staff were rushed and people were not provided with the care, support and comfort they needed. Staff received training and support to carry out their roles, however we found some staff did not have the skills or competencies to meet the needs of people living with dementia.

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.

People were not always treated with respect by staff or had their privacy and dignity maintained. Although some staff were kind, caring and compassionate and treated people well, other staff were task focussed and did not respond appropriately to people's needs.

There was a lack of consistent and effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level. Effective systems were not in place to address shortfalls identified at the inspection and drive improvement.

People were supported to keep in touch with family and friends through video, phone calls and indoor visits. Activities were taking place. People had access to healthcare services and received their medicines when they needed them. People were provided with plentiful supplies, and a choice of, food and drinks.

The provider was responsive to the inspection findings, took action during and after the inspection and shared plans to improve their systems and processes.

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 20 October 2018).

Why we inspected
We undertook this focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about falls and risk management. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

We inspected and found there were concerns with risk management, so we widened the scope of the inspection to become a comprehensive inspection which included all the key questions.

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.

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from good to inadequate This is based on the findings at this inspection.

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 Cooper House Care Home 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 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 safeguarding, safe care and treatment, staffing, dignity and respect and good governance 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is 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 caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Cooper House 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
Four inspectors, a medicines specialist professional advisor and an Expert by Experience carried out this inspection. 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
Cooper House 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 who had applied to be registered with the Care Quality Commission. The registration process was completed during the inspection. 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 announced. We announced the inspection from the car park shortly before entering the service on 27 May 2021. This was because we needed to check the arrangements in place for preventing and containing transmission of COVID-19 prior to entering the building. Inspection activity started on 27 May 2021 and ended on 11 June 2021. We visited the service on 27 May and 7 June 2021. The other dates were spent reviewing information off site and making phone calls to staff.

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 commissioners and safeguarding team and 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 prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection-
While on site we spent time with people in the communal areas observing the care and support provided by staff. We spoke with ten people who used the service about their experience of the care provided. We spoke with 19 members of staff including the manager, unit managers, nursing, housekeeping and care staff.

Discussions with people who used the service, relatives and staff were conducted either on site or by telephone calls. We reviewed a range of records. This included 13 people's care records and 31 people's medicine records. We looked at two staff recruitment files. 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. We made a safeguarding referral to the local authority safeguarding team regarding concerns we had identified during the inspection.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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
- Risks to people were not assessed and managed safely.
- Care records did not explain how to keep people safe. For example, some people were distressed and displayed behaviours that challenged but there was no guidance for staff about how to support and manage the person.
- Where risks had been identified, actions had not been taken to ensure people's safety. For example, care records stated action had been taken to protect people who were at risk of harm from certain items, yet people still had access to these items.
- Staff were not following guidance to keep people safe. One person, assessed at high risk of choking, was given food which was not compatible with the soft diet they were prescribed.
- Another person's care records showed they were at high risk of falls and advised staff to encourage the person to use their walking frame and ensure it was in easy reach. We observed the person walking around all day and they had no access to a walking frame.
- The environment was not always safe or well maintained.
- Locks had been removed from some bedroom doors leaving a hole in the door and a glass panel was missing from a fire door in a corridor. This compromised fire protection.
- Furniture in some people's bedrooms was broken, damaged or had parts missing which posed a risk of injury or harm to the individual.
- Not all accidents and incidents were reported, investigated or dealt with appropriately.
- Some accident and incident reports identified lessons to be learned and listed actions that had been taken to prevent a recurrence. However, we found these actions had not always been implemented.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to address the risks.

Preventing and controlling infection
- We were not assured the provider was using PPE effectively and safely. Staff were not wearing PPE correctly. We saw staff coming into the home without masks on, staff wearing masks below their noses and on occasions under their mouths. Staff were not always donning and doffing PPE correctly and there were not suitable facilities for them to do so. Staff were not always bare below the elbows. Staff with very long

hair had it tied back but not up off their shoulders. Some staff came to work in their uniforms although this was not in accordance with the provider's uniform policy.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Some parts of the building were not clean. Cleaning schedules did not evidence regular cleaning particularly in relation to touch points. Hygienic practices were not implemented when the pet rabbit was present in communal areas.
● We were not assured the provider was meeting shielding and social distancing rules.
Social distancing was not always implemented. On the first day of inspection staff arrived on shift and congregated together to sign in. There was a lack of social distancing in communal areas.
● We were not assured the provider was making sure infection outbreaks can be effectively prevented or managed.

People were not protected from the risk of infection as control measures were not implemented consistently. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during after the inspection. They confirmed actions had and were being taken to ensure infection control procedures were followed by all staff.

● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding procedures were not followed consistently. For example, a choking incident had not been investigated or reported to safeguarding.
● Staff did not always recognise abuse. We witnessed staff using unlawful restraint with one person. We made a referral to the local safeguarding team about this practice.
● Actions had not been taken to safeguard people who were at risk of harm. Lessons had not been learned from other serious incidents which resulted in people being further exposed to risk of harm.

The provider failed to ensure people were protected from the risk of abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to safeguard people.

Staffing and recruitment
● There were not always enough suitably qualified, competent, skilled and experienced staff deployed to meet people's needs and keep them safe.
● People we spoke with said if they needed staff they came. Some people said they had to shout for staff as they did not have a buzzer; others said they had a buzzer which they used.
● A dependency tool was used to calculate staffing levels which were implemented. However, our observations showed the deployment of staff was not effective.

● Staff were continually busy and were not available to respond promptly when people needed care, support or comfort. We saw people sitting in the same chairs for long periods of time without assistance.
● Staff were not always present in communal areas where people were gathered. An argument between two people escalated into physical contact; staff attended when they heard raised voices.
● People received inconsistent care and support. The use of agency staff and the movement of staff between units meant staff were not always familiar with the people they were supporting or knew their needs.
● Some staff did not demonstrate the skills and competency to manage the complex needs of people living with dementia.

We found no evidence that people had been harmed, however systems were not in place to ensure sufficient suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs and keep them safe. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to review the staffing arrangements.

● Recruitment processes were safe with all required checks completed before new staff started employment.

Using medicines safely
● Medicines were managed safely.
● People said they received their medicines when they needed them. Comments included; "They [staff] do my medicines and always on time" and "They [staff] come and bring me my tablets, because I forget."
● Medicines were ordered, stored, administered and disposed of safely.
● Medicines administration records were well completed with no gaps. Staff used codes to explain why people had not received their medicines.
● People's medicines were monitored and reviewed regularly by the advanced nurse practitioner who visited the service on a weekly basis.
● Staff administering medicines had received training and had their competency assessed.

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.

- Systems were in place to monitor DoLS applications and authorisations and to make sure conditions were met.
- Capacity assessments and best interest decisions were recorded for some decisions where people lacked capacity. However, decision making processes were not always robust.
- One person had moved to a different unit and there was no evidence to show a best interest decision process had been followed. Another person was resisting care on a daily basis and staff were using restraint to deliver the care; this was not recorded or recognised as restraint by staff.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to ensure decisions made on behalf of people who lacked capacity complied with the MCA.

Adapting service, design, decoration to meet people's needs
- The service was purpose-built and provided spacious accommodation for people. However, some parts of the environment were in a poor state of repair and required refurbishment.
- Some people's bedrooms were comfortably furnished and personalised, yet other people's rooms were stark in comparison with damaged furniture and no personal effects.
- The environment did not always meet the needs of people living with dementia or promote their

independence. For example, bathrooms and toilets had pictorial signs however some of these rooms were locked and not accessible to people. There were no names or signs on bedroom doors to help people identify their rooms.

The provider responded during and after the inspection.They confirmed actions had and were being taken to ensure the environment was well maintained and refurbished.

Staff support: induction, training, skills and experience
● Staff confirmed they received an induction and ongoing training which was kept up to date. This was confirmed by the staff training matrix.
● However, some staff did not have the skills and competencies to manage the needs of people living with dementia, particularly people who displayed behaviour that may challenge others.
● Staff said they received supervision and this was confirmed in the records we reviewed.

The provider responded after the inspection. They confirmed actions had and were being taken to address ensure staff had the training and competencies to meet the needs of people living with dementia.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●People's needs were assessed before they moved into the service. Due to COVID-19 information had been gathered through phone calls with the person, relatives and relevant health and social care professionals rather than through face to face meetings.
●The assessment was used to develop care plans and risk assessments.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional needs were met.
● People told us they enjoyed the food and we saw they were offered plenty to eat and drink throughout the day.
● Menus were displayed in the dining rooms. People were offered a choice and staff helped people to choose by showing them the different options available
● Staff encouraged and supported people who were reluctant to eat. We hard people saying how much they had enjoyed their lunch. Comments included; "It was lovely"; "Very nice" and "Smashing."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff supported people to access the healthcare support they needed. However, one person had not received the chiropody support they required, although this was arranged when we raised the issue.
● People's care records confirmed the involvement of other professionals in providing care such as the GP, district nurses, social workers and speech and language therapy (SALT) team.
● The advanced nurse practitioner visited the service on a weekly basis to review, advise and respond to any changes in people's health care needs.

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always treated with kindness and compassion by staff.
- People's experiences varied. Some staff were very kind and caring. For example, staff had a lovely approach when supporting one person to transfer in a hoist saying, "Come on let's get you in a comfy chair, we're going up, hold on to here, hold tight, that's it."
- However, we also observed staff who lacked warmth and empathy and were not responsive to people's needs. We saw people who were visibly upset and shouting, pacing the floors. Some staff ignored them and other staff were heard telling people repeatedly to sit down or calm down which did not ease people's anxiety.
- Some staff were more focussed on completing tasks than they were on people's wellbeing. Yet we saw other staff, despite being busy, took time to check people were all right and provided comfort and support where needed.

Respecting and promoting people's privacy, dignity and independence
- People's privacy and dignity was not maintained and staff did not always treat people with respect.
- We saw some people going into other people's bedrooms and lying on their beds. Staff were aware this was happening but took no action.
- Some people's bedrooms were unclean, contained furniture which was damaged and contained little or no personal effects.
- Some people looked unkempt. Their hair was dishevelled and they had were wearing no footwear.

Supporting people to express their views and be involved in making decisions about their care
- Staff did not always explain things clearly or in ways that people could understand. We saw a person whose first language was not English trying to communicate in their own language with staff. Staff responded by repeatedly asking the person to speak English which caused the person to become more distressed. No other methods or aids were used to help communication.
- Relatives were kept informed. Care records had evidence that relatives were contacted about events, such as if a person had fallen or was unwell.

People were not treated by staff with compassion, dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken

to ensure all staff treated people with respect and maintained their dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- People did not always receive person-centred care.
- People's care records were variable. Some contained person-centred information about the care and support people required, others lacked detail and did not reflect the person's current needs. For example, one person's care plan stated staff were to monitor and record the person's whereabouts hourly. Staff told us this was no longer happening and the care plan required updating.
- There was a lack of guidance for staff in how to support people who displayed behaviours that challenged. Daily records described people being agitated but there was no detail to show what had happened, when, who was involved or how long the episode had lasted.
- People's care was not properly monitored. Staff made entries in people's daily notes, but these did not always reflect people's experience.

We found people's care records were not accurate, complete or contemporaneous. This placed people at risk of receiving inappropriate care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to ensure care records were accurate and complete.

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.

- People's communication needs were not always met.
- Staff were not aware of the different ways of communicating with people and did not always recognise the importance of giving people time to respond.
- People were not always provided with accessible information. One person's care records stated staff should use pictures to aid communication. Staff confirmed they did not have any pictures to use. This was addressed when we raised it and communication books were introduced for people whose first language was not English.

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 social care needs were not always met. We saw some people enjoyed a variety of activities including pamper sessions, discussing the daily newspaper with staff and taking part in a beach party. Yet we also observed people sitting for long periods of time without any stimulation or interaction from staff.
● People were supported to keep in touch with family and friends. This included pre-arranged internal visits where government guidance was followed to keep people and their visitors safe.
● Activity staff were employed and a list of planned events was displayed throughout the home. We were shown photos of a party held in the home to celebrate Eid al-Fitr.

Improving care quality in response to complaints or concerns
● Effective systems were in place to manage complaints.
● A complaints log was maintained which showed complaints had been investigated and responded to appropriately.

End of life care and support
● Care records showed discussions had taken place with people and their relatives about individual wishes and preferences in respect of end of life care.
● Arrangements were in place for relatives to visit safely and spend time with people who were receiving end of life care.
● People had RESPECT (Recommended Summary Plan for Emergency Care and Treatment) forms at the front of their care files which gave an overview of individual needs if emergency care was required. For example, one person's form stated they could become disorientated and agitated in strange environments.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Significant shortfalls were identified at this inspection. There were breaches in relation to safeguarding, risk management, infection prevention and control, staffing, dignity and respect. These issues had not been addressed through the provider's own governance systems.
- There was a lack of effective management and leadership.
- The manager was not fully aware of what was happening in the service. Although they completed daily quality walk arounds they had not identified or addressed many of the issues we found. For example, poor infection control and environmental risks. Their knowledge of people using the service was limited.
- Issues we identified on our first visit to the home, and reported to the manager and senior managers, had not been addressed when we returned on the second day. This included issues related to infection control, the environment and risk management.
- The reporting and management of risks to people including accidents, incidents and falls was unreliable and inconsistent. We identified risks and incidents which had not been reported, investigated or acted upon.

- Quality audits were not effective in identifying issues and securing improvements. There was a lack of continuity and completion of the audit cycle in terms of actions identified and subsequent follow up. The manager confirmed there were no audits in place for wounds or pressure ulcers or to monitor people's weight.
- People did not always receive person-centred care that led to good outcomes for them. Care records were not always accurate or up to date.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to improve the leadership, management and governance.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong
● The manager understood the requirements of the regulations to make notifications and to comply with duty of candour responsibilities when things had gone wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People we spoke with during the inspection gave positive feedback about the care they received. Comments included; "It's five star because of the staff, they do everything for us" and "I feel content, they are all nice people here."
● Records showed relatives were kept informed of events and care needs of their family member. We saw compliments received from relatives thanking staff for the care they had provided.
● Minutes for recent residents' meetings showed people were involved in choosing and planning activities and events.
● A variety of meetings were held regularly with staff to communicate information and gain their views. Staff told us they were able to raise issues but were not always informed what action had been taken in response.
● Records showed the service liaised with a range of health and social care professionals in meeting people's needs.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people using the service were treated with dignity and respect at all times. Regulation 10 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that people using the service were protected from abuse and improper treatment. The provider failed to ensure that people using the service were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (1)(5)(7)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to assess and mitigate risk to people using the service. The provider failed to ensure the premises was safe for use. The provider failed to assess, prevent and control the risk of infection. Regulation 12 (1)(2)(a)(b)(d)(h)

The enforcement action we took:

Warning notice

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	The provider failed to ensure effective systems were in place to assess, monitor and improve the quality and safety of the services; assess, monitor and mitigate the risks to people using the service and to maintain an accurate, complete and contemporaneous record of people's care and treatment. Regulation 17 (1)(2)(a)(b)(C)

The enforcement action we took:

Warning notice