Birmingham City Council

Ann Marie Howes Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Ann Marie Howe Centre is a purpose-built care home registered to accommodate and deliver personal care to a maximum number of 32 people. At the time of this inspection there were 25 people living at the Ann Marie Howe Centre, receiving personal care, who were over 65 years of age and living with dementia and/or physical disability.

People's experience of using this service and what we found:
Inspectors found care and treatment was not always provided in a safe way. The registered manager had failed to take prompt action to update peoples risk assessments, exposing people to harm. People had personalised care plans, but these were not always updated following a review or change in circumstances. People did not have personalised activity plans and people were not effectively supported to avoid social isolation.

Systems and processes were not effective in assessing, monitoring and mitigating the risks relating to environmental health, safety and welfare of people. Audits had not taken place for over a year, exposing people to harm. People did not have complaints but knew how to make a complaint if they needed to. The registered manager understood their duty of candour but did not operate a lessons' learned process.

Infection control was not effectively managed, people were not always protected from cross contamination as continence pads, stoma bags, and personal protective equipment was not safely stored.

People were not always supported to maintain a balanced diet. Specific dietary needs were not always met, and fluid monitoring was ineffective. People did not always receive a coordinated approach between the care home and external health services. People did not always attend planned health care appointments or receive planned health care tests. This led to people experiencing on going symptoms and remaining at risk of ill health.
People received medications as prescribed. Staff did not always record the reason for administering `as required` topical creams, or the outcome of using them, preventing effective reviews of outcomes, for people using this medication.

People received mixed outcomes regarding promoting independence and being treated with dignity and respect. Staff were kind and caring and respected confidentiality and people's privacy.

Staff received induction and refresher training and either had a health and social care qualification or had completed the care certificate.

MCA
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies in the service supported this practice

but the systems did not.

The registered manager did not have a process for identifying when Deprivation of Liberty, (DoLS), authorisations expired and DoLS authorisations had expired prior to new authorisations being applied for. Staff were not clear on how DoLS related to their daily practice in delivering care, or which people had a DoLS in place.

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 11 July 2017).

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make significant improvements. Please see the all sections of this full report. The provider has taken some action to mitigate the risks identified at inspection. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from good to Requires Improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Anne Marie Howes Centre on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment and good governance, at this inspection.

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

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

Follow up
We will 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?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Ann Marie Howes Centre

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of one inspector and one assistant inspector.

Service and service type
Ann Marie Howe Centre 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.

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 who work with the service. 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. This information helps support our inspections. 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-
We spoke with six people who used the service about their experience of the care provided. We spoke with eleven members of staff including the registered manager, deputy manager, two senior care staff, four care

workers, the chef, two laundry assistants and a visiting health care professional.

We completed checks of the premises and observed how staff cared and supported people. 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 cannot talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four 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 registered manager to validate evidence found. We looked at training data, falls records and quality assurance records.

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.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Learning lessons when things go wrong

- The registered manager failed to mitigate risks or put in place systems and processes to keep people safe from avoidable harm. This meant they failed to ensure care and treatment was being provided in a safe way, putting people at risk of poor and unsafe care.
- Some people were experiencing multiple falls. The registered manager failed to carryout falls analysis or investigations. This meant that people were at immediate and ongoing risk of harm from falls. One person had sustained 21 falls between June 2019 and January 2020. Another had experienced five falls in December 2019.
- One person had a specific diagnosis of a food allergy. The care plan did not set out the risk, mitigation or action to be taken, if the person experienced an allergic reaction. Staff were not aware of the allergy and continued to give the person the foods to which they were allergic. The registered manager did not know the background to this allergy.
- One person was prescribed a specific diet by their GP. Inspectors identified this diet was not implemented for a six-month period as the registered manager failed to ensure care staff, kitchen staff or the persons family were made aware of the diet. This meant the person's health and wellbeing was placed at risk of avoidable harm.
- People's fluid intake and hydration was not monitored, where this was required. We found people's target fluid intake was not entered into the electronic monitoring system and this meant staff were not alerted, where fluid intake was not enough for good health and wellbeing. This meant people were exposed to risk of avoidable harm.
- Where the service had identified risk, the registered manager did not have a process in place to ensure the risk was properly mitigated. One person was at risk from weight loss and there was a delay in proposed actions being taken, for example blood tests. Another person was at risk of falls and an external meeting requested, in November 2019, had never taken place. These delays occurred as the registered manager did not have a follow up process in place. This meant people's known risks were not effectively mitigated, and people remained at risk of avoidable harm.
- Garments used to promote continence were not stored appropriately. We saw continence pads and stoma bags out of their packaging, left lying out in the open rubbing against other items on the staff station. They did not look clean or suitable for use. This meant that people were at risk from cross infection.
- We saw staff were using personal protective equipment (PPE) such as gloves and aprons. Inspectors saw an allocation of aprons left in a laying loose, rubbing against other items on the staff station, at the beginning of the shift. This meant people were at risk from cross infection.
- Inspectors saw first aid box's in the Marylin and Tom Units were not kept in a clean condition, the box

fastenings were broken, disused wrappers from items previously used were still lying in the boxes and there was not a record of when the boxes had last been inspected. This meant the first aid items required may not be available when people needed them.

●Cleaning fluids were not always safely stored. Inspectors saw cleaning fluid had been put in a cupboard that also contained diluting juices. The cupboard was in a kitchen accessible to people and visitors. Inspectors asked staff to relocate the cleaning fluids to prevent the risk of ingestion.

● Inspectors discussed, with the registered manager, learning lessons when things go wrong. The registered manager advised that there was not a specific process to capture this information. This meant people were at risk of repetitive harm.

The failure to do all that is reasonably practicable to mitigate risk to people using the service was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not consistently safeguarded. The registered manager was aware of their responsibilities to keep people safe from avoidable harm but was not taking appropriate action. For example, where people had unobserved falls resulting in broken bones, a safeguarding alert was not sent to the Local Authority safeguarding team. Residents told us they felt safe. One person told us, "I would speak to any staff member if I had concerns." Staff we spoke to at this inspection told us they had received training in safeguarding and knew where the safeguarding policies were. Staff explained the signs of abuse and who they would report them to. One staff member told us, "I would spot bruising, or if like the citizen [person] behaved different than they usually do, I would report to the manager and document."

Staffing and recruitment

● The registered manager stated they did not use a dependency tool to match people's needs to staffing requirements. The registered manager explained there was a budget to determine staffing levels. Inspectors observed staffing levels meant people were sitting for long periods of time unaccompanied in the lounges, without the benefit of meaningful activities. One person told us "There are enough staff members when needed and when wanted." A staff member told us "I do not have time to read the risk assessments, instead I rely on the handover, but I try to make time to read them." Two staff members expressed a view there were insufficient staff and an over reliance on agency workers. Another staff member advised inspectors there was not enough time to complete care charts, so often urine and bowel records were not maintained, this was confirmed by the records we saw. This meant staff may not identify when people were at risk of ill health, as a result of this.

● We saw additional staff were made available for specific needs, when this was required. For example, one member of staff was providing end of life care on a one to one basis. This meant the person always had a member of staff with them.

●There had not been active recruitment in the past year. The registered manager informed inspectors staff were currently being recruited. Inspectors found safe recruitment processes were in place to ensure new staff were suitable to work with vulnerable adults.

Using medicines safely

● We saw when people were administered `as required` topical creams, staff were not recording the reason the topical creams were required or the outcome of application. This meant it may not be possible to effectively review of these medicines to ensure good outcomes for people.

● Inspectors found that people received their medications as prescribed. Staff told us they had received training in administration of medication and records confirmed this. One person told us, "I am aware of

what medication I take, it is explained before I take it. I get it on time." One member of staff told us, "I feel confident when administering medication."

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.

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.

Ensuring consent to care and treatment in line with law and guidance

- At the time of this inspection only one person had been deprived of their liberty. The registered manager told inspectors that this had not been notified to the care quality commission.
- The registered manager did not have a process for identifying when DoLS needed to be reapplied for. This meant the DoLS authorisations had expired prior to being reapplied for meaning people were unlawfully deprived of their liberty.
- Staff were not clear on how DoLS related to their daily practice in delivering care, or which people had a DoLS in place. One staff member told inspectors there were two DoLS in place, another thought there was one, but it had expired, and another said they could not remember. Staff were not able to identify why the DoLS were in place. We did not see any restrictive practices that were not proportionate to the degree of potential harm.

The failure to report to the CQC an authorisation to deprive a person of their liberty, was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registrations) Regulations 2009 (Part 4)

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

● People's needs were assessed but were not always updated when needs or risk changed. People told us they were given choice, but inspectors found care plans and risk assessments did not record the decisions and choices people had made. This meant staff did not have guidance about people's decisions and choices. As a result, people's preferences may not be followed, for example an agency worker who may not know the person well enough to know their preferences. One person told us, "If you don't know they [staff] will tell you what your choices are."
● People were involved in day to day decision making and staff gained people's consent prior to delivering the service. People told us, "Staff ask for agreement before providing any care."

Staff support: induction, training, skills and experience
● Staff told inspectors they had received induction and refresher training and records confirmed this. Records showed staff either had a health and social care qualification or had completed the care certificate. Staff had not received training in Oral Care. This may leave people at risk of harm from poor oral hygiene. The registered manager told inspectors this was planned for January and would be completed by the end of the month.
● People were not always supported by staff who had the necessary skills and experience to do so. Inspectors saw agency staff were deployed in the service. We saw two-agency staff deployed in the Tom unit working with a senior care assistant. This meant people were being supported by staff who did not know them, their needs or preferences. Inspectors saw the senior staff member was directing these staff what to do on a task by task basis. A staff member told us, "Agency workers who come are support workers and do not have enough knowledge to be working in the service. So, staff must show them everything such as changing a pad which takes up more time. Although care is received it impacts on spending time with people and not having enough one to one time with them."

Supporting people to eat and drink enough to maintain a balanced diet
● People did not always receive specific diets, prescribed by health care professionals, to support their health care needs. Records showed, where a specific diet was needed, or fluids needed to be monitored, this did not always happen. Staff we spoke with were not able to identify who was at risk of choking and who required a specific diet. One person had not received their specific diet for six months. This meant people were at risk of harm from unmanaged conditions such as diabetes. The registered manager agreed to review the risks of those affected. One member of staff told inspectors, "I do not have time to sit with people to ensure nutritional needs are met."
● We saw that people could snack and make a drink at any time. People told us they liked the food and had enough to eat. One person told us, "It's like a hotel here, the food is divine." Another person told us, "I've never had better home cooked food."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People did not always receive a coordinated approach between the care home and external health services. Records showed the registered manager did not have a follow up system in place and this had led to people not attending appointments or for health care tests, for example blood tests. This had led to people experiencing on going symptoms or accidents such as weight loss or falls. The registered manager agreed to follow up on those people who, at the time of this inspection, were identified to be at prolonged remaining at risk of ill health.
● There was an arrangement in place between the district nurses and the care home to provide people with a district nurse clinic at the care home. A health care professional told inspectors, "We are here regularly, and the service staff work well with us." This meant that people with appointments could easily access the clinic.

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

- People's bedrooms were personalised and reflected people's preferences and choices.
- People had their own shower rooms. Communal bathrooms and toilets were also available. Inspectors saw these were being used as wheel chair stores. The registered manager explained that the bathrooms were not used, but the toilets were. This affected people using the toilet as this was an unsafe environment.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- While individual staff were kind, the providers system meant that some people were not cared for.
- People's independence was not always promoted. We saw mixed outcomes for people's independence. People's independence was affected when accessing facilities, for example the hairdresser and gardens. Access to the hairdresser was within a part of the building not occupied by the care home. This meant that people had to be escorted. One person told us, "I like going to the hairdresser, but I was not made aware [of the hairdressers] until a few days into living at the service." Access to some of the gardens was also from a part of the building that was not occupied by the care home, which meant people could not independently access them. Inspectors saw people's independence was promoted by staff. Inspectors saw staff encouraging people to do things independently rather than doing it for them, for example making a drink.
- People's dignity and respect was not always promoted. People told us they were treated with dignity and respect. However, inspectors saw a person walking around the home with a catheter visible. There was a person in the dining room wearing their pyjamas, who informed inspectors they had been waiting for over an hour to get dressed and did not like being in the dining room or eating their breakfast in their pyjamas. Inspectors later saw this person eating breakfast in their pyjamas.

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

- People described staff as kind and caring and said their privacy was respected. One person told us, "They [staff] close the door when attending to personal attendance." People felt staff knew them well, one person told us, "I think they seem to get to know you, that is the impression I got." Another person said, "I am not aware of staff names but know them by faces, I am okay with this."
- People were supported to celebrate birthdays. We saw banners, balloons and cards in the lounge. Inspectors saw positive interactions between people and staff in the lounges. One person said, "I feel staff listen to me."

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

- The registered manager explained people and their families were involved in the decision making about their care at the pre-admission, care planning and reviewing stages. Inspectors saw from records, relatives updated the registered manager on decisions they had taken about their relative's care. However, the registered manager had not supported the relative, by discussing the decision with them or considering the impact that these decisions may make on the ongoing needs of the person and how these would be met.

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's care plans were not always updated following a review or change in circumstances. People did not have personalised activity plans. This meant staff who were not familiar with a person would not have a point of reference for people's social needs and preferences.
- The registered manager could not show evidence of how people and their relatives were involved in the care planning process or how changes were communicated to them.

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 care plans did not always set out a person's preferred method of communication. One staff member said a person had difficulty with verbal communication, and used lip reading and visual cues, but this was not recorded in their care plan.
- People were shown a choice of two plated meals from which to choose. There was no information available at the table, either in pictorial or written menu format. This meant people were not able to decide or consider their choices, prior to the plated meals being shown to them.
- Communal notice boards were in use. However, these were not used to communicate with people about up and coming events such as activities.

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

- We saw that group events for specific occasions were organised by the service. There was not a dedicated activities person and the staff dependency calculations did not allow for additional staff to provide day to day social activities.
- People were not effectively supported to avoid social isolation. We saw people sitting in the lounge either sleeping or looking at passing people and staff. People we spoke with about activities spoke about the hairdresser but were not able to recall any other regularly available activities. One staff member told inspectors "There is not enough to do for people and there are not many meaningful activities available, because of the staffing levels." Another staff member said, "I do try and gather all the people in the communal area and start conversations, however some staff are lazy and do not do this." Another staff member identified a person that liked colouring and inspectors saw colouring books and crayons were available to the person in their room. One staff member said, "This is not the problem of staff or

management, it's finding the time, wish someway they would bring `activities people` into the service."
● People were able to go out into the community with their friends and families. Staff were not able to take people into the community due to staffing levels. We saw this from the records and heard it from people and staff. One staff member said, "Staff cannot take citizens [People] out for lunch because of short staffing levels, it's impacting on day out activities."

Improving care quality in response to complaints or concerns
● The provider had a complaints policy. People told us they had no complaints but knew how to complain and would go to any member of staff to do so.
● The provider did not operate a lessons learned process. This meant people may experience repeated poor service.

End of life care and support
● The registered manager did not use end of life care plans. This meant staff could not be sure they were delivering the service in the way the person wanted. Staff followed the direction of the district nursing team and family members, to ensure people's choices were followed.
● End of life care was delivered on a one to one basis, ensuring the person had the dedicated attention of the staff member. One staff member told us they had received training in end of life care, another two staff could not remember. One staff member told us, "It is making sure they are comfortable by asking them if they would like to do anything, making sure someone is in their room, having one to one so person knows there is someone there for them."

Requires Improvement

Is the service well-led?

Our findings

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

At 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; Continuous learning and improving care

- Inspectors found the registered manager failed to effectively operate the provider's governance systems and therefore failed to identify multiple areas of concern identified at this inspection or mitigate risk. The registered manager told Inspectors the last internal audit of the service was in 2018. The lack of quality assurance meant opportunities to identify areas for improvement within the service was lost.
- The provider's governance systems had not identified planned care and treatment had not taken place, for example blood tests and the introduction of specific diets. This left one person at risk of ongoing weight loss, one person's dietary needs were not met for a six-month period and another person had been given a food they were allergic to. This placed people at unnecessary risk of on-going harm.
- The provider's governance systems had not identified staff were not recording the outcome of `as required` topical medications, or not all staff administering medications had had their competency checked. This placed people at avoidable risk of harm from poor medication administration and recording practices. Inspectors saw a forward plan for practice observations, this had not commenced at the time of this inspection. We will look at how this is working, at the next inspection.
- The provider's governance systems had not identified infection control equipment and continence garments were not kept in a condition fit for use, placing people at avoidable risk of harm, from cross infection.
- The provider's governance systems did not identify where people were having their fluid intake monitored, target quantities had not been input to the system and therefore staff were not alerted if people were not sufficiently hydrated. This placed people at unnecessary ongoing risk of harm.
- The provider's governance system did not identify where people were experiencing multiple falls, the registered manager had not reviewed or mitigated risk following each fall. One person declined to attend a falls clinic appointment and the registered manager did not follow up on the remaining risk. Inspectors brought this to the attention of the registered manager, who arranged for a review of people experiencing multiple falls.
- The provider's governance system did not identify fridge temperatures were at an unsafe level over a period of three days, during the week of this inspection, and no action had been taken. Inspectors brought this to the attention of the registered manager who took one fridge out of action and arranged for maintenance.

The failure to have effective systems and processes in place to monitor and mitigate risks to people was a

breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Following this inspection, the registered manager sought medical advice for the people identified as being at risk or not receiving agreed care and treatment, agreed to put a process of communication in place between care staff and kitchen staff and agreed to ensure fluid targets were entered into the electronic system.

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

● People knew who the registered manager was and spoke positively about them. One person said, "The manager listens, everything is first class."

● Inspectors found there was a lack of opportunity for people to be involved in the service. People told us they had not attended residents' meetings or been asked to take part in a survey about the service. The registered manager confirmed this. People told us they were happy living at the home, one person told us, "It's lovely, they [Staff] don't bother you if you sit and watch the television." Another person told us, "It is better than some that I have been in the past."

● There were mixed views from staff on the culture and leadership of the service. Staff talked of a lack of teamwork and low morale and one staff member stated, "That is the reason why information is not shared effectively to all." One staff member said, "All at the top have no passion, seems weak, not [managers name] fault, I do not feel they are supported in their role." Another staff member told us, "Staff do not see management on the floor, they are always outside doing what they are doing." Other staff told inspectors that staff made this a good place to work one said, "Absolutely, because we are all lovely people."

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 in relation to their duty of candour. Inspectors saw where concerns were identified, at this inspection, the registered manager immediately actioned their duty of candour procedures.

Working in partnership with others

● The registered manager worked in partnership with a range of other people and health care professionals to improve outcomes for people using the service. These included, families, GP, Mental Health Team, and District Nursing. There was not a system in place to follow up agreed actions and this meant people did not always get the agreed treatment. Following this inspection, the registered manager agreed to introduce a follow up system, to ensure outcomes for people improve. We will review this at the next inspection.

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 The provider failed to do all that was reasonably practicable to mitigate risk to people using the service.

The enforcement action we took:

Notice for positive conditions.

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 effective systems and processes to monitor and mitigate risks to people using the service.

The enforcement action we took:

Notice for positive conditions.