Care Expertise Group Limited

Holmwood Nursing Home

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?	**Inadequate**

Summary of findings

Overall summary

About the service
Holmwood Nursing Home is a care home providing personal and nursing care to 23 people aged 65 and over at the time of the inspection. Some of the people may be living with dementia. The service can support up to 48 people.

People's experience of using this service and what we found
There had been some improvements at the service. The previous manager had left which had slowed the pace of improvements, despite the provider remaining legally responsible for the quality of the service at all times. The new manager had been in post since May 2019 and acknowledged more work was needed. The further, recent change in management had led to some confusion to people and relatives about who was responsible for the care to be delivered. Staff felt supported but work needed to be done to ensure staff worked together effectively as a team.

People were not always protected from the risk of abuse as incidents were not always recognised as potential safeguarding concerns or reported where appropriate, to the local authority. Risks to people were managed well with improvements in the recording of people who required specialist input to keep their skin intact. Medicines were administered appropriately however action was needed to make sure medicines did not take too long to be given. There were enough staff to meet people's needs and action was taken to monitor incidents and accidents to prevent a re-occurrence.

People's needs were not always appropriately assessed. This is an area that needs to be addressed particularly when the service starts admitting new people. People were not always 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. People were not always treated with dignity and respect through occasional lack of thought by staff. Care planning had improved however time was needed for this to be embedded into staff practise.

The mealtime experience was positive for people however there needed to be consideration as to how the environment and people's rooms could be decorated in line with their needs and wishes. People were involved in the planning of their care and encouraged to be independent where possible. Activities had improved with thought being given as to how people could be encouraged and engaged. Staff were aware of people needs and care planning, including for end of life, care planning had moved fully to an electric system which had enhanced accuracy. Feedback form visiting healthcare professionals was that the service was improving.

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

Rating at last inspection and update – The rating at the last inspection was Requires Improvement (published 3 May 2019) and there were multiple breaches of regulations. The provider completed an action

plan after the last inspection to show what they would do and by when to improve. At this inspection some improvements had been made but these need to be sustained and the provider was still in breach of some regulations.

Why we inspected
This was a planned inspection based on the previous rating and to follow up on action we told the provider to take at the last inspection.

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

Enforcement
We have identified breaches in relation to person-centred care, dignity and respect, consent 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
The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We have done this as there is still one key question rated as 'Inadequate'. 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. We will continue to monitor information we receive about the service until we 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? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Holmwood Nursing 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.

Inspection team
The inspection was conducted by three inspectors and a specialist nurse advisor.

Service and service type
Holmwood Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 in post who was in the process of registering with the Care Quality Commission. Registering means 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 action plans and information shared with CQC by the local authority, information we held about the service including feedback received and statutory notifications. Statutory notifications are reports of events that providers have a legal duty to notify us of.

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
We spoke with five people, three relatives and eight members of staff. This included the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a visiting GP. We reviewed a range of records including five care plans and medicines records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures

After the inspection
We asked for information to be sent to us by the provider to confirm what they had told us on inspection.

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 Requires Improvement as risk was not always managed well. At this inspection this key question has remained the same. 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

- One relative said, "Mum has been here for two years and I feel she is safe." One person said, "I do feel safe here because the staff look after me." One member of staff said, when asked about protecting people from abuse, "First of all I'd go the nurse or the senior. If I'm alone I'd call my colleagues in. I'd call the police if nothing was done."
- Despite this people were not always protected from the risk of abuse. Not all staff were clear about the steps they should take if they suspected abuse was occurring or recognise when incidents could be considered as a safeguarding issue. For example one person had unexplained bruising which had been raised with staff by their relative. Staff had completed an incident form but the management team had not reported this the local authority.
- At the last inspection there was a lack of clarity about who made decisions to refer safeguarding concerns to the local authority. This had still not been addressed as staff were still being told to report incidents to the management team who decided whether it should be notified to the local authority. This led to incidents not always being recognised as safeguarding concerns or being reported appropriately.

Failure to have established and effective systems to prevent abuse is a breach of regulation 13 (Safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were given safely however improvements were needed in the time staff spent administering them to people. There were people who required medicines in the morning. Staff took over two hours to administer medicines to 11 people. By the time this finished the lunchtime medicines round was due to start. Whilst we were assured people who required time critical medicines received these appropriately there was a risk others might not have sufficient gaps between taking their medicines.
- Medicines were stored and disposed of safely. Medicines were held in a secure clinical room only accessed by nursing staff. Medicines were clearly accounted for and well organised to minimise the risk of people missing their medicines.
- We observed the medicines round and found staff gave medicines to people appropriately and described to them what they were taking and why. One person told us, "I always get my medicines on time."

We recommend the provider reviews the length of time medicines take to be administered and explores way of improving this.

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

At our last inspection in March 2019 risk was not always assessed and managed well which was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements had been made and the breach had been met however time was now needed to ensure it was embedded into staff practise.

● Risks to people with poor skin integrity had been an issue at the last two inspections. This had improved with staff now following guidance and ensuring people were turned appropriately. One relative told us, "They are checking on [person] changing positions, checking to see if [person] is in pain. Their care is consistent." Where people had pressure mattresses in place we found these set correctly for their weight which reduced the risk of skin damage.
● People had been at risk in the event they needed to be evacuated as personal evacuation plans (PEEPs) had inaccurate information them. This had been addressed, all people now had accurate PEEPs in place which clearly outlined how they should be supported if needed.
● Other risks to people were responded to effectively. One person was at risk of malnutrition and required this to be monitored regularly. This was being done and their weight had remained stable as a result. Another person had a catheter in place which was regularly checked by nursing staff.
● Accidents and incidents were recorded and analysed to help keep people safe and prevent re-occurrence. Each incident was reviewed and where necessary steps taken to address any issues identified. For example it had been noticed that two people could sometimes be aggressive to others. In order to reduce these instances it was recognised the deployment of staff needed to be improved. The way staff were allocated was changed to address this.

Staffing and recruitment
● There were enough staff to help keep people safe. People who required support were attended to quickly by staff. One member of staff said, "According to our number of residents, we have enough staff members. People aren't left waiting for care as there is always someone around."
● Since the last inspection the staffing levels had been maintained. More nursing and care staff had also been recruited to help reduce the use of agency staff and increase consistency of care.
● People were supported by staff who had been appropriately recruited and vetted prior to appointment. Checks included a full work history, references and a check with the Disclosure and Barring Service (DBS). The DBS keeps a record of staff who would not be appropriate to work in social care.

Preventing and controlling infection
● The improvements made at the last inspection had been sustained. There were two members of staff responsible for maintaining the cleanliness of the home. All areas of the home were clean, tidy and well organised, this included the kitchen, laundry and sluice rooms.
● Staff used personal protective equipment to maintain good infection control. One member of staff told us, "We always wear gloves and aprons. They are always available."

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 Requires Improvement as people did not always receive care that was assessed as being needed and the Mental Capacity Act 2005 was not always followed. At this inspection this key question has remained the same. 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

At our last inspection in March 2019 consent was not always obtained appropriately which was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvements had still not been made and the breach had not been met.

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.

- People's capacity was still not always being assessed in line with the MCA. One person lacked capacity for certain decisions like having their medicines given to them by staff. There was a capacity assessment and best interest meeting held for this but not for consent in relation to media use. The person did not have capacity for either decision. Another person told us, "I don't like it here. It's not suitable for me." They had a community treatment order under the Mental Health Act 1983. This required them to comply with certain conditions however it was unclear whether the current order was still in place. Staff had not taken steps to clarify this or to ensure the order was current. This meant they were not obtaining consent appropriately and the person could be at risk of being restrained unlawfully.
- Staff told us how they asked for consent, and we saw, people being asked for consent for day-to-day decisions like what they wanted to eat or whether they wanted to take part in activities. Staff listened to people and respected their decisions. One member of staff told us, "We can't judge that somebody has no capacity until its proven."

● The communal area still had a coded lock on the door that restricted people's movement. We were told this was because one person repeatedly tried to leave the service. Other less restrictive practice had still not been considered or attempted. We did note that stair gates that were previously in place had been removed.
● A number of care staff had not received training in the MCA or DoLS which meant they may not recognise when consent was not being obtained appropriately.

Failure to obtain consent in line with the MCA was a continued breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

At our last inspection in March 2019 person centred care was not always assessed or provided appropriately which was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvements had still not been made and the breach had not been met.

● Following the last inspection the service had admitted one person with complex mental health needs but were now struggling to meet their needs. The manager told us they did not think the placement was suitable for them. One member of nursing staff told us," I don't think [person's] needs can be met." Pre-admission assessments were not robust and did not ensure the service could meet people's needs. There was a reliance on other healthcare professionals confirming the placement was suitable. The manager raised this with the local authority following the inspection.
●The environment for people living with dementia still required further improvement. Whilst there had been some changes since the last inspection this needed further work to make the environment suitable. Some people's rooms lacked personalisation and were bare with limited adaptations made to make them feel homely.
●The provider had commissioned a consultant to address this and provided us with their report. This also confirmed more work was needed to make the environment more dementia-friendly and personalised. We will report on this and any improvements made at our next inspection.

Failure to fully assess people's needs or provide a suitable environment was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People received support from healthcare professionals because staff made appropriate referrals when the need arose.
●One person told us they had recently needed to have the GP called and staff organised this promptly and arranged for the relevant tests to be done. Another person required specialist input from a tissue viability nurse due to poor skin integrity. A relative told us there were regular visits by healthcare professionals. One said, "The doctor had been in to see [person]."
● Staff told us, "Communication is good," whilst other healthcare professionals confirmed nursing staff took more responsibility, than previously, for ensuring they had the right information when they visited.
● Other healthcare appointments were made for people to ensure their health was maintained.

Staff support: induction, training, skills and experience

● Staff training and competency needed to be monitored to ensure their training was embedded into practise. Staff told us, "The training is good here. I'm up to date with it all. There is lot of training, like dementia, dysphagia (Swallowing difficulties). That was really helpful." Staff had received training in all areas to help meet people's needs such as dementia training and nutrition and diet however this was not always put into practise. For example at lunchtime one member of staff was assisting a person to eat. They were giving them food too quickly which did not give them time to swallow their food.

● Nursing staff were able to confidently explain their roles and how they kept up to date with changes to clinical best practice. A visiting GP told us that nursing competency had improved since the last inspection. They said, "Things are better. My job is easier as they [nurses] are doing a better job."

● The manager told us staff had supervision every two months which included clinical supervision for nurses. Staff also told us they received this however records provided after the inspection showed this was an area that needed to be improved as not all staff had received them.

● There had been new members of staff employed since the last inspection. The manager told us staff had an induction to help them settle into their new role and to understand people's needs. One member of staff told us they had an induction but did not receive training in moving people safely. We saw them assisting people to move throughout the day and raised this with the manager to address.

We recommend the provider reviews the induction, supervision and training procedures to ensure staff received the support required to work effectively.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us they enjoyed the food and staff knew their food preferences however one person was unhappy with the choice of food on offer. One person said, "I'm a fussy eater I know if I fancied something off the menu I would be able to ask for it, they're very good like that." Staff told us the food quality had improved. One told us, "The food quality is much better since the new chef had been employed."

● The food looked appetising and we saw people enjoying their meals. Staff offered support to help people eat where appropriate. People who required specialist food had this provided by a chef who knew their needs well. The chef used moulds for pureed food which made the meal look appetising.

● Staff recorded people's food and fluid intake when needed. The manager would be alerted by the electronic case system if someone had not had enough to drink. People's weights were reviewed regularly and action taken to refer to them for dietician input if needed.

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 Requires Improvement as staff did not always treat people with dignity and respect. At this inspection this key question has remained the same. 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, Supporting people to express their views and be involved in making decisions about their care, Respecting and promoting people's privacy, dignity and independence

At our last inspection people were not always treated in a caring, respectful way and were not always involved in decisions about their care. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Some improvements had been made however the breach had not been met.

● People and relatives gave mixed views on the caring nature of staff. One person told us, "Staff vary. There are a lot of new staff. Some try (to be caring) and others are impatient." Another person had a more positive experience. They had been anxious about a family member and staff had helped them. They said, "I've been so worried, so told [staff member] and she called her for me and made sure she was okay, I was so grateful for her doing that and I feel so much better now."
●A relative told us staff were, ""Angels in disguise, they are so kind the care they give is second to none." Whilst another relative told us, "The nurses are really fantastic."
● As with the previous inspection we saw several examples of staff speaking and acting kindly towards people. Staff responded to people who required support and did so in a way that helped settle them.
● However we also saw examples where staff did not always consider people's dignity. For example one person was sitting in a chair with their feet elevated. Staff were seen to move their legs without speaking to them and standing over them with a drink without any interaction. On another occasion a member of staff wiped a person's mouth with a napkin and used the same one to wipe someone else's mouth. This was not dignified or hygienic. This was raised with the manager to address.

Failure to treat people with dignity and respect is a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Peoples independence was promoted by staff where possible. One person told us, "I've been getting better with my mobility and independence and they let me do as much as I can do and then let me ask for help when I need it. Staff knew what people could do for themselves. One said, "[Person] is eating everything independently. [Person]has difficulty walking and personal care. [Person] can wash their face and I do the rest."
● Improvements had been made in how people were involved in their care however further work was

needed. One person told us, "[Member of staff] came to my room and we went through what I could do myself like brushing my teeth, and what I needed help with such as washing." The service was using a new electronic care planning system, some care plans were accurate and had been recently updated whilst others needed more information in them.

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 Requires Improvement as peoples care plans were not always accurate or up to date. At this inspection this key question has remained the same. 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; End of life care and support; 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

At our last inspection people not always receiving personalised care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements had been made and the breach had been met however the provider needed time to demonstrate this can be sustained.

● Since the last inspection care plans had moved to an electronic system. Care plans now had more personalised information in them and relatives told us they were kept up to date with any changes in their care. One relative said "They [staff] ring me if there is ever a problem. "Staff were able to describe people's needs, preferences, likes and dislikes. One person had an interest in a certain type of music and period in history. This was clearly recorded in detail for staff to read.
● Staff had handover meetings at the start and end of each shift to ensure all concerned knew of any changes in the care people needed. If people needed support staff knew the signs to look out for.
● End of life care plans had improved. One person had an end of life care plan which had been completed with involvement with their family. This set out how they wanted to be cared for in the future.
● Activities had also improved. The service now employed two activity co-ordinators. Feedback from people was that activities had much improved. One person told us, "They know I don't like taking part in group activities because I'm a bit of a loner. If the carers have a spare minute they'll come and sit next to me and have a chat or we do a word search together."
● Staff also told us activities had improved. One said, "They're very good. We have one in the morning and evening. We've got two people who sit in their room. [Person] requested someone to do this [sit with them] the other day so we took it in turns to chat with her."
● In the morning people were enjoying a game with the activities staff. Others were doing arts and crafts with staff. In the afternoon there was a silent disco. This is where people are given headphones to listen to the music. This means other people who did not wish to participate were not affected. People were seen interacting and dancing with each other and it was clear the activities co-ordinator knew them and how best to engage and encourage them to take part.

Improving care quality in response to complaints or concerns
● There had not been any complaints since the last inspection. The complaints procedure was displayed

visibly in the service.

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.

- Care plans contained relevant information about people's communication needs. There was guidance for staff on how to support one person who could become anxious when raising issues with staff.
- Picture menus were used at mealtimes to assist people in making food choices.

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 Inadequate as improvements had not been made quickly enough after the inspection in September 2018. At this inspection this key question has remained 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.

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

At our last inspection there was not an effective quality assurance system in place. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some improvements had been made in some areas however the breach had not been met as breaches either continued or new ones were identified.

● There had been a recent change of manager as the previous one had left. As a result the deputy manager had been promoted. The inconsistent management of the home left people and relatives not always knowing who had overall responsibility for the care being provided. A relative told us they had, "No idea" who the manager was and had assumed it was one of the nurses. We raised this with the provider and manager who told us this would be addressed in a newsletter to relatives. One person told us, "[Manager] is very good. She walks around every morning and says hello."
● At the last inspection there was a lack of leadership and direction at the service. We saw there were improvements in respect of this with senior staff being more present and visible when staff were supporting people. Despite this there were still times when staff could have been guided more and standards set when incidents of unthinking care occurred. One person had become upset as they thought they had a hairdressing appointment. Two staff tried to calm them and resolve this but gave contradictory information to them. It took several minutes to resolve this before a member of the management team came and told them they would be having their hair appointment.
● Staff told us more needed to be done to make the team work well together. One said, "Team work still needs improving. There are some issues with the culture here." The manager told us there had been two new senior care staff posts created and training was to be provided to help with improving staff understanding and teamwork. We noted some staff were in uniforms whilst others were not. This meant it was difficult to know what their role was. The manager told us they were introducing new uniforms to address this and make it clearer for people and relatives.
● Management oversight and support had increased which had led to improvements, however there were still issues in relation to the environment, how safeguarding incidents were notified and obtaining people's consent. These areas still need to be addressed in a timely way. The nominated individual told us there was

still, "A lot of improvement needed," but reinforced their commitment to make sure the changes needed were put into place.
● Audits of the service covered all areas including call bells, care planning and medicine administration. Despite this there was still work to do as noted in the rest of this report. Some of the audits had still not identified the concerns and breach of regulations we found in relation to the application of the MCA, safeguarding procedures and the inconsistent approach of staff in respect of dignity and respect. Effective auditing should have identified these issues and led to improvements.

Failure to effectively monitor and quality assure the service leading to continual improvements is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● Relatives and residents' meetings took place and we saw there were positive comments made about a recent food event that was held. Other areas discussed at the meetings were activities, compliments and complaints. It was not clear how feedback was obtained from people who could not verbally communicate or how they were involved in the meeting itself. This is an area that needs to be developed.
● Staff also told us they were supported by the management team now in place. One member of staff said, "We learned a lot, made us realise where we had been falling short of standards. I feel valued." Staff had supervisions where they had opportunities to discuss their performance or any areas of learning they may have however, these needed to be more regularly held. Team meetings also took place where important matters relating to the service were discussed. We noted from the minutes there was reference to action being taken against staff if they did not follow certain procedures. The tone of the minutes was not one that would support a positive culture and focused on staff being told what to do rather than being an open discussion on the subject matter. Work is needed to ensure meetings are inclusive and supportive towards staff.
● There had been further improvements in how the service worked in partnership with other agencies. A recent local authority monitoring visits had acknowledged the improvements that had been made.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Peoples needs were not fully assessed and the environment for people living with dementia required improvement.

The enforcement action we took:

We issued an NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity or respect

The enforcement action we took:

We issued an NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Peoples consent was not always obtained in line with the MCA

The enforcement action we took:

We issued an NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not always recognise incidents that required reporting to the local authority. The systems to report these were unclear

The enforcement action we took:

We issued an NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had not identified the breaches of regulations found and had not improved the service

The enforcement action we took:

We issued an NOP