Select Lifestyles Limited

Select Lifestyles Limited - 512-514 Stratford Road

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Select Lifestyles Limited – 512-514 Stratford Road is a care home without nursing providing accommodation and personal care to up to six people. Six people lived at the home at the time of this inspection.

People's experience of using this service and what we found
Right Support
People did not receive good quality person centred care and support. People were not supported to contribute to planning and reviewing their care and making decisions about their lives, which included planning their meals or deciding how they spent their time. This demonstrated their voices were not always listened to. People did not have the maximum possible choice and control over their lives, and they did not have enough opportunities to gain independence. Accepted poor staff practice meant people's dignity was not maintained and their right to privacy was compromised. People did not always receive their medicines when they needed them, which was unsafe. People had access to health professionals, but action was not always taken when staff had identified medical treatment was needed.

Right Care
People did not always receive safe care and support because risks associated with their care were not always assessed. Staff understood people's preferred methods of communication but many interactions between people and staff were task focussed. Also, staff did not have all of the information they needed to provide care in line with people's wishes. Some staff had not received all of the training they needed to meet people's specific needs and others did not put their learning into practice. Staff recruitment checks needed to be strengthened. The home was not a clean and pleasant place for people to live and infection prevention and control practice was unsafe. Multiple risks associated with the environment had not been identified or mitigated. Systems were in place to ensure people were protected from the risk of abuse and harm.

Right culture
A person-centred culture with clear outcomes for people was not promoted. Discussions and observations demonstrated person-centred approaches were not understood or embedded into practice. Leadership of the service was poor. The providers quality assurance systems were ineffective and had not been operated in line with their expectations. This meant opportunities to drive forward improvement and learn lessons had been missed. Some prompt responsive action was taken in response to our inspection feedback and further action was planned to improve outcomes for people.

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 last rating for this service was good (published 09 November 2019).

Why we inspected
We received concerns in relation to staffing levels. We also undertook this inspection to assess that the service is applying the principles of right support right care right culture.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. The provider was in breach of regulations in relation to person-centred care, dignity and respect, safety and good governance. Please see the safe, caring, responsive and well-led sections of this full report.

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.

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.

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

The overall rating for this service is 'Inadequate' and the service is 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 reinspect 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 in 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 caring Details are in our caring findings below.	**Inadequate**
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**

Select Lifestyles Limited - 512-514 Stratford Road

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Select Lifestyles Limited - 512-514 Stratford Road is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Select Lifestyles Limited 512-514 Stratford Road is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
Our first visit to the service was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since our last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also gathered feedback from local authority commissioners who work with the service. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with one person to find out what is was like to live at the home. We observed the care and support provided in communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with one person's relative and one person's advocate about their experiences of the care provided. We spoke with four members of care staff including agency staff, the operations manager, three locality managers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed six people's care records and four people's medication records, staff training data, a range of policies and procedures and a range of records relating to the management of the service. We reviewed the recruitment records of two staff to check they had been recruited safely. We shared our inspection findings with two local authorities.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- Risk management was inadequate. Risks associated with one person's mobility and the equipment staff used to help them move around their home had not been assessed. That meant information staff needed to provide safe care was not available to them.
- Risks were not always well managed. One person had sore and itchy skin. Medical advice or treatment to alleviate the symptoms was not taken until we bought this to the attention of the operations manager. This same person at times wore a specialised garment to prevent them from damaging their skin. Guidance was not in place to inform staff about the garment or when the person needed to wear it.
- Risk assessments did not always provide staff with the information they needed to provide safe care. One person's risk management plan failed to inform staff they needed to administer an important medicine to manage symptoms of a medical condition at a particular time.
- Staff did not always follow instructions to manage risks. A person was at risk of choking on food. To minimise this risk health care professionals had advised staff not to assist the person to eat when they were drowsy or asleep. We saw a staff member assisted the person to eat their lunch whilst they were drowsy. This was unsafe.
- Environmental risks were not always identified and mitigated. For example, the rear garden was not secure because the gate latch was broken. Also, multiple cleaning products some containing harmful chemicals were accessible to people. This was unsafe.

Safe care and treatment was not provided. Risks had not always been assessed, identified or mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During our inspection visits some action to improve safety including, starting to assess risks associated with people's care, seeking healthcare advice and repairing the rear garden gate was taken. Further remedial action was planned.
- Staff did know about risks associated with people's care. However, they gave differing accounts when we asked them how they managed risks.
- One person told us they felt safe living at the home. A relative told us safe care was provided. Staff had completed safeguarding training and knew how to identify and report concerns. One staff member said, "If I saw bruises on anyone's skin, I would report it and do a body map."

Using medicines safely

- People did not always receive their medicines. Three people's prescribed creams and two people's

medicated lotions had not been applied to their skin as required which placed them at risk.
● Some creams in use did not have a prescription label or their dates of opening recorded. That meant the provider could not be sure who the creams belonged to or demonstrate the creams were being used within recommended timescales and were effective.
● The room used to store medicines was dirty and cluttered. The temperature of the room had not been recorded on nine occasions between 01 and 22 August 2022 to demonstrate medicines had been stored within a suitable temperature range.
● Three tubs of thickening powder were not stored safely and were accessible to people. This was unsafe. In 2015 NHS England issued a storage safety alert following the death of a care home resident who died after accidentally ingesting a thickening powder. Thickening powders are added to fluids for people who have been assessed at risk of choking when eating and drinking.

Medicines were not managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visits some of the medicines concerns we identified were shared with the local authority safeguarding team for further investigation.
● Whilst staff completed medicines training and their practice to administer medicines safely was assessed our findings confirmed they had not put their learning into practice.
● After our visits action including reassessing the competency of staff members to administer medicines safely was taken. The nominated individual told us a new electronic medicines system was being implemented in an attempt to improve safety.

Preventing and controlling infection
● We were not assured the provider was using PPE effectively and safely. Multiple staff members were observed either not wearing face masks or wearing their face masks incorrectly under their chins and noses. This unsafe practice was bought to the attention of the nominated individual for them to address.
● We were not assured the provider was preventing visitors from catching and spreading infections. During our first visit inspectors were permitted to enter the home without being asked for evidence of a negative COVID-19 lateral flow test. This unsafe practice placed people at risk.
● We were not assured the providers infection prevention and control policy was up to date. The policy was not followed by staff to prevent infections spreading and to keep people safe.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Multiple areas of the home including people's bedrooms were dirty, and laundry was not managed in line with best practice. Regular cleaning to ensure cleanliness of the home did not take place.
● We were somewhat assured that the provider was admitting people safely to the service. However, guidance was not in place to help staff manage any new admissions to the home safely.

Risks associated with preventing and controlling the spread of infection had not always been identified or mitigated. This placed people at risk of harm and was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some action was taken during and after our visits to improve cleanliness and infection prevention and control practice. This included the home being deep cleaned on 23 August 2022.
● We were assured that the provider was accessing testing for people using the service and staff.

Visiting in care homes
The provider did not always facilitate visits for people living in the home in accordance with current

guidance. Staff told us visits to the home had to be pre booked. Action was taken to address this.

Staffing and recruitment

● Information we received prior to our inspection indicated staffing levels were too low. During our visits there were enough staff on duty to meet people's physical needs. However, staff told us there were not always enough of them to support people to go out.

● Despite discussion with managers and requesting information during and after our visits, it was unclear how the provider determined the number of staff needed on each shift to meet people's needs.

● Aspects of staff recruitment needed to be improved because employment references were not always checked in line with the providers policy. Disclosure and Barring Service checks had been completed. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● A relative told us enough staff were on duty, but the use of agency staff was high. They added, "There's a lot of new faces I haven't seen before, they don't introduce themselves. Its unsettling."

● The nominated individual told us staff recruitment was a challenge and regular members of agency staff were being used to cover staffing shortfalls. They went on to explain a new manager and three new staff members had been recruited. They were due to start work at the home during September 2022.

Learning lessons when things go wrong

● Accidents and incidents were recorded. However, records had not always been fully completed to demonstrate if any action had been taken to prevent recurrence. In addition the process to identify themes and trends needed to be improved.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Restrictions had been placed on one person's liberty to keep them safe in line with the MCA. However, information in relation to this was not available to staff. That meant the provider could not be sure care and support was provided in the least restrictive way to uphold the person's rights. The operations manager took action to address this.
- One person told us staff did seek their permission before they provided care. Staff had completed training to help them understand the principles of the MCA. We saw staff gained people's consent before they provided care in communal areas.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- One person told us they had contributed to an assessment to help them decide if the home was the right place for them to live. Their assessment had included protected characteristics, as identified in the Equality Act 2010, including their religion and culture. However, records of completed assessments could not be located during our visits.

Staff support: induction, training, skills and experience
- Staff had not completed all of the training they needed to meet people's specific needs. For example, a staff member who had worked at the home since 08 July 2022 had not completed autism or epilepsy training. The operations manager told us they would arrange for the training to take place.

● New staff completed an induction when they started work at the service. However, feedback staff provided indicated this needed to be improved to ensure staff knew what was expected of them and to help them get to know people. One staff member told us, "I came and had a look round on the Friday. I started work on the Saturday. No shadow shifts or anything like that."
● Staff completed The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff had opportunities to attend meetings with their managers to help guide them with their work and continually improve their practices.

Supporting people to eat and drink enough to maintain a balanced diet
● Whilst a person told us, and we saw people were supported with a balanced diet, it was not clear how people were involved and encouraged to plan their meals. Food menus were not in place and feedback about the food provided was not gathered. Managers were unable to provide an explanation for this.
● Care records contained some information about people's dietary requirements, food allergies, their likes and dislikes. Staff knew what people liked to eat and drink and told us how they supported people to choose what they ate. One staff member said, "At lunchtime I showed (Name) tuna and ham which helped them to choose a sandwich filling."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff monitored people's health, but action to address concerns they had identified was not always taken. We have reported on this in the safe section of this report.
● A relative told us the service did arrange healthcare appointments for their family member. However, they were not always informed about this or any treatment that had been provided to them. We shared this with the nominated individual for them to address.
● Records confirmed people did have access to the healthcare professionals they needed including district nurses.

Adapting service, design, decoration to meet people's needs
● Whilst people's bedrooms contained their personal belongings such as their family photographs the provider could not demonstrate people had been involved in deciding how their home was decorated.
● In March 2022 the provider had identified some areas of the home required improvement. For example, the dining room needed new flooring, a new table and redecoration. Whilst some action had been taken to improve the exterior of the building not enough action had been taken to ensure the home was a nice environment for people to live in.
● Despite our findings people liked their living environment which included an accessible garden, communal lounges and a kitchen.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- People's dignity was not always maintained. One person told us they had not received the support they needed to use the toilet from staff which made them feel degraded.
- People were not always treated with respect. The language staff had used to describe a person in their care records was disrespectful. When we spoke with a staff member about another person, they told us they could be 'demanding' and 'vocal if they didn't get their own way'. This approach was not caring.
- People did not have enough opportunities to maintain and increase their independence. One person said they would like to make their own drinks and bake cakes in the kitchen. They went onto explain they could not do that because the worktops in the kitchen were too high for them to reach and use.
- People's right to privacy was not protected. One person's private conversations in their bedroom was overheard by other people and staff through an electronic monitor located in the communal lounge. The electronic monitor had been in use for seven weeks. Whilst we acknowledge this was not intentional this poor practice had been accepted.
- Staff did not always support people to make daily decisions. For example, during our SOFI observation a staff member changed the television channel without consulting the people who were watching it. On another occasion a staff member set up a game up in front of a person who was seated at a table without asking them if they wanted to play it.

People were not always treated with respect and did not have opportunities to be involved in making decision about their care . Privacy and dignity was not always maintained and independence was not promoted. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some action was taken in response to our feedback. For example, the electronic monitor was removed.
- The nominated individual acknowledged our findings. They told us they would take action to improve outcomes for people, including holding a staff meeting to remind staff of the provider's expectations.
- Whilst we saw staff showed people some kindness during our visits many interactions with people were task focussed and staff did not sit and talk to people for a meaningful length of time. For example, staff said hello to people as they walked through the lounge but did not give people time they needed to respond.
- One person described staff as 'nice' and a relative told us they were, "Overall happy with the care provided."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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; 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

- Staff did not have all of the information they needed to provide personalised care. For example, care plans for many aspects of a person's care such as, oral care had not been completed. The person had lived at the home since 01 July 2022.
- Some completed care plans contained inaccurate information and others lacked information to help staff provide the care people needed. This was important because some people could not tell staff about how they wanted their care to be provided.
- Whilst the provider's approach to care planning was outcome focussed, people were not always supported to achieve meaningful goals. One person's goal to access the community on a regular basis had not been achieved due to a staffing shortfall. The person's relative told us they supported their family member to go out to make sure they got some fresh air on a regular basis.
- People were not supported in ways that promoted their aspirations. One person wanted to access further education and learn new skills. No consideration had been given to their request until we bought it to the attention of the nominated individual.
- Staff told us on occasions there were not always enough of them on duty to support people to go out in line with their needs and wishes. A staff member said, "I think there could be more staff. When three staff are on its hard. If we had more staff, we could take more people out more often." During our visits some people did not have opportunities to go out despite staff telling us outings for those people were planned.
- People were not always supported to spend time doing things they enjoyed and were of interest to them. A staff member told us a visit to a garden centre was planned. When we asked if people liked visiting garden centres they replied, "Well I think so, it's usually been the manager who tells us where to take people." This demonstrated person-centred approaches were not understood.

The care and support provided did not always meet their needs or reflect their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The nominated individual told us they would take immediate action to make improvements to benefit people. This included obtaining support from specialist activities staff from within the provider group to support people to follow their interests and take part in activities they enjoyed.
- Discussions with staff confirmed they did know the people they cared for. For example, a staff member knew one person likes music and another liked to go shopping.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Information about people's preferred methods of communication were not always documented to help staff communicate effectively with people. However, our observations confirmed staff understood what people's nonverbal communication including their body language and gestures meant. A staff member commented, "People do have their little ways of communicating."
● The nominated individual was aware of the AIS. Some information including the providers complaints procedure was available in picture format which people could understand.

Improving care quality in response to complaints or concerns
● A person and a relative told us they knew how to complain or raise concerns about the service. The person said, "I would tell my mom or my social worker or the staff. It would get sorted out."
● The provider investigated and responded to complaints in line with their policy.

End of life care and support
● The service was not supporting anyone at the end stage of their lives at the time of this inspection. The operations manager told us training in this area would be provided to staff if it was needed.
● Care records contained some information about people's end of life wishes.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The leadership and governance of the service was inadequate, and the quality and safety of the service had significantly deteriorated since our last inspection. The lack of provider and management level oversight meant people were at risk of receiving unsafe, poor quality care.
- The provider had not ensured their systems to monitor the quality and safety of the service were effective. For example, checks had not identified staff did not always have the information they needed to provide safe and responsive care. Also, some audits and checks required by the provider had not been completed.
- Opportunities to drive forward improvement and learn lessons had been missed. Action had not been taken despite a medicines audit identifying improvement was required in July 2022. In addition, the provider had not taken enough action between March and August 2022 to ensure the environment was a nice place for people to live.

The provider had failed to ensure their systems and processes were established and operated effectively. Accurate and complete records in respect of each person were not maintained. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People deserve good care as a minimum. The nominated individual explained failings had occurred because the previous management team at the home had not worked in line with the providers expectations. The multiple breaches of the regulations we have identified demonstrate the provider had not taken enough action to address those failings.
- The provider had not kept up to date with best practice guidance such as CQC's policy on Right support, right care, right culture or the quality of life tool now used when inspecting services supporting people with learning disabilities or autistic people.
- When we shared our inspection findings with the nominated individual, they told us they would take action to make improvements. Following our inspection visits we received a variety of information to confirm some actions had been taken and further action was planned.
- A new manager was due to start work at the home during September 2022. As an interim measure the operations manager and locality managers were working at the home to start making necessary improvements.
- The latest CQC inspection rating was on display in the home and was available on the provider's website. The display of the rating is a legal requirement, to inform people, those seeking information about the home

and visitors of our judgements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● People did not receive personalised care and the culture of the organisation was not shaped and led by people. People were not listened to. Their feedback to make service improvements was not encouraged.
● At the time of our visits meetings with people or their relatives did not take place and it was not evident how some people contributed to making decisions about their care and support or how they lived their lives.

The provider had failed to seek feedback from relevant persons to continually evaluate and improve the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A relative felt communication needed to be improved. They told us they did not know who had been running the service since the previous manager had left and they did not always feel informed about their family members care. The nominated individual told us they would address this. In contrast a person's advocate felt communication between them, and the service was good.
● Staff felt supported and told us they enjoyed their jobs. One staff member described the culture within the home as, 'like a family'. Another told us, "We have been through a rocky patch which was down to poor leadership. We are on the up."

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 nominated individual and operations manager demonstrated a shared commitment to making improvements. They were disappointed with our inspection findings and acknowledged standards had fallen below the providers expectations. They were open and honest during our inspection visits and told us they would use our feedback to focus their improvement activities.
● The operations manager informed us they were working in partnership with a local authority to drive forward necessary improvement. Local authority commissioners confirmed an improvement action plan was in place prior to our 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 9 HSCA RA Regulations 2014 Person-centred care 9 (1) (a) (b) (c), (3) (a) (b) (d) People did not always have opportunities to be involved in making decisions about their care. Care and support provided did not always meet peoples needs or reflect their preferences.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect 10(1)(2)(a)(b)(c) People were not always treated with respect. Privacy and dignity was not always maintained and independence was not promoted.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12, (1)(2)(a) (b) (d) (g) (h) Safe care and treatment was not provided. Risks associated with peoples care and support, the environment and preventing and controlling the spread of infection had not always been assessed, identified or mitigated. Medicines were not managed safely.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance (1)(2)(a) (b) (c) (e) Systems and processes were not established and operated effectively. Accurate and complete records in respect of each person were not maintained. The provider had failed to seek feedback from relevant persons to continually evaluate and improve the service.

The enforcement action we took:

Warning Notice