ADA Care Limited

Regency Court

Inspection report

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20 July 2022
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Regency Court is a residential care home providing personal care to up to 22 people in one adapted building. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 13 people using the service.

People's experience of using this service and what we found
People were not always safe. Actions had not been taken to safeguard people from abuse. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks. Accidents and incidents were not always appropriately recorded. Medicines were not managed safely.

There were not always enough staff to meet people's needs and keep them safe. Recruitment processes were not robust in checking people were safe and suitable to work in the service.

People did not always receive person-centred care and care records did not fully reflect their needs. People were not always treated with dignity and respect and their experience of care varied. Some staff were kind and caring, however others interacted very little with people. There were few activities taking place and there was little to occupy and interest people. People's dignity was not always respected.

Infection control procedures were not followed on the first day as staff were not wearing masks correctly though this had improved on the second day.

There was a lack of effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level.

People's nutritional needs were met although the recording of people's food and fluid intake needed to improve. Staff training and support had improved. Training was up to date and staff were receiving supervision. People were supported to keep in touch with family and friends. People had access to healthcare services. Relatives were satisfied with the service provided.

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 and systems in the service supported this practice.

The manager and provider were responsive to the inspection findings and responded during and after the inspection to address the issues we found..

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 inadequate (published 30 November 2021) and there were 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 we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding, staffing, recruitment, person-centred care, privacy and dignity and 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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Regency Court

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
Two inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Regency Court 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. Regency Court 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
This inspection was unannounced. Inspection activity started on 20 July 2022 and ended on 12 August 2022. We visited the service on 20 July and 8 August 2022.

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 and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 used all this information to plan our inspection.

During the inspection
We spent time with people in the communal areas observing the care and support provided by staff. We spoke with three people who used the service and seven relatives about their experience of the care provided. We spoke with the nominated individual and seven members of staff including the manager, senior care workers, care workers and the cook. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included nine people's care records and eight people's medicine records. We looked at three staff recruitment files. A variety of records relating to the management of the service were reviewed.

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 inadequate. At this inspection the rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People's safety was not maintained and they were not protected from the risk of abuse.
- Staff had received safeguarding training, however, safeguarding incidents were not always recognised or acted on. Records showed people had sustained unexplained bruising and skin tears. These had not been investigated or referred to the local authority safeguarding team.
- During the inspection an incident occurred where one person assaulted another person. No staff were present and the inspector had to intervene to keep people safe. On a different day another person left the service unbeknown to staff and fell outside sustaining a serious injury. Although action was taken after both these incidents to ensure people's safety, systems had not been in place to manage these risks and keep people safe.

People were not protected from the risk of abuse as control measures were not implemented consistently. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the inspection findings and sent information to show they were taking action.

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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Risks to people were not assessed and managed safely.
- Weight loss was not monitored or managed effectively. Records showed two people had lost weight in recent months, however it was not clear what action was being taken to address the loss.
- People were not repositioned in accordance with their care plans increasing the risk of pressure damage developing.
- We observed staff using unsafe moving and handling practices when assisting people to mobilise which placed people at risk of harm and injury.
- Environmental risks were not identified and acted upon which placed people at risk of harm or injury. For example, broken furniture in people's rooms and a door left open at the top of a staircase where people's bedrooms were located.
- Accidents and incidents were not always reported, investigated or dealt with appropriately. Incident forms

were not always clear about what had actually happened and no investigations had been carried out to establish the facts. Care records showed accidents and incidents had occurred which were not reported or recorded on incident forms.
● Lessons learned were not always implemented. One person who had repeated unwitnessed falls was to be checked every one to two hours. We observed these checks were not taking place.

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

The provider responded to the inspection findings and sent information to show they were taking action.

Using medicines safely

At our last inspection the provider had failed to ensure safe medicine management systems were in place. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Medicines were not managed safely.
● Medicines were not always stored safely and securely. Prescribed creams were left out in people's bedrooms, a prescribed thickener and food supplement were stored in the kitchen. The medicine trolley was stored securely in the dining room but there were no room temperature checks to ensure safe temperatures were maintained.
● Systems for administering prescribed creams were not clear. Topical medicine administration records (TMAR) were not always in place to show staff when, where and how often to apply creams. There were gaps on TMARs where staff had not signed, so we could not be assured creams had been applied.
● Protocols were not always available for 'as required' medicines and those that were in place were not always accurate.
● Patch charts had been put in place to record when a medicine patch was changed and where on the body the patch had been applied. However, we found gaps where the location of the patch had not been recorded.

Systems were either not in place or robust enough to demonstrate medicines were managed safely. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the inspection findings and sent information to show they were taking action.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient staff deployed at all times to meet people's needs. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

● There were not always enough staff deployed to meet people's needs and keep them safe.
● On the first day of the inspection occupied communal areas were frequently left unattended by staff.

People who required support with their needs and protection from others were placed at risk of harm or injury as they had no means of summoning help and no staff were present. On the second day a staff presence was maintained in communal areas.

● During the day three care staff were on duty. Several people at the service required the support of two staff with their care needs. This left one member of staff in the lounge. However, if someone called for assistance or there was an incident then the staff member in the lounge would have to respond. At night there were only two staff on duty which made it untenable for a staff member to be in the lounge when it was occupied.

● The provider had implemented a dependency tool to calculate staffing levels. However, this was ineffective as it did not take into account the layout of the service or the risk of harm to people.

There were not enough staff deployed at all times to meet people's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the inspection findings and sent information to show they were taking action.

At our last inspection the provider had failed to ensure staff were recruited safely. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● Recruitment processes were not robust as checks to establish a candidate's fitness for the role were not suitable and sufficient. For example, two references had been received for one staff member. Both references contained only dates of employment, and one stated they could not provide any information about the candidate as they were only employed for a week. There was no evidence of any additional checks being made to obtain appropriate references. There was missing information on the application form for another staff member, including dates of employment.

Systems were not in place to ensure staff were recruited safely. This placed people at risk of harm. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the inspection findings and sent information to show they were taking action.

Preventing and controlling infection

● Government guidance on the prevention and control of infections was not always followed. On the first day staff were not wearing personal protective equipment (PPE) correctly. We saw multiple occasions where staff were wearing masks below their noses and under their mouths. This had improved when we returned on the second day and staff were wearing masks correctly.

● Cleaning schedules were in place and most areas of the building were clean although there was an odour of urine in one bedroom. The provider said this would be addressed.

● Staff were completing lateral flow device (LFD) tests twice a week in accordance with government guidance.

● The provider was facilitating visits for people living in the home in accordance with the current guidance. Relatives were happy with the visiting arrangements. They said the booking system worked well and they completed LFD tests prior to visiting.

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 requires improvement. The rating for this key question has remained 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 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, 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.

At our last inspection the provider had failed to ensure people's care and support was delivered in line with the MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

- The service was working within the principles of the MCA.
- A DoLS tracker was in place which showed when applications had been made and granted and whether the authorisations had any conditions.
- One DoLS authorisation which had been issued recently had a condition and the manager was taking action to ensure the condition was met.
- Mental capacity assessments and best interest decisions (BID) were in place for some restrictions but not all. No assessments and BIDs had been completed for some people who had bed rails or sensor equipment in place. The manager said action would be taken to complete these.

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

At our last inspection the provider had failed to ensure people's nutritional needs were met. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14.

● People's nutritional needs were met although improvements were required in monitoring and recording food intake.
● On the first day we observed people were served small portions of food and were not offered seconds. This had improved when we visited on the second day.
● We were not assured that food and fluid charts were accurate as they were completed retrospectively by staff who had not observed the amounts people had eaten and drunk. The manager said they had addressed this with staff, however this practice continued on the second day we visited.

The provider responded to the inspection findings and sent information to show they were taking action.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to provide the staff with the training and support they required to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Staff received the training and support they required to carry out their roles.
● Staff told us training had improved since the last inspection and this was confirmed by the training matrix and staff records we reviewed which showed training had been updated.
● Records showed new staff completed an induction.
● Staff said they felt supported by the new manager and records showed staff had received supervision in the last six months.

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

● People's needs were assessed before they moved into the home. A pre-admission assessment had been completed for the most recent admission to the service and provided details of the person's care and support needs.
● The building was adapted to meet people's needs, parts of the environment had been redecorated and a new carpet fitted since the last inspection. Bedroom doors had been painted different colours and had people's names and photographs displayed to help people identify their own room.

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

● Staff supported people to access the healthcare support they needed.
● People's care records confirmed the involvement of other professionals in providing care such as the GP, district nurses and optician.
● The manager advised staff were unable to access the Telemeds system as the device they had was not working and required a charger. Telemedicine is the remote diagnosis and treatment of patients by means of telecommunications technology.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

At our last inspection the provider had failed to ensure people were treated with compassion, dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

- People were not always treated with kindness and compassion by staff.
- Some staff were warm and friendly, engaged with people and treated them kindly. However, other staff did not take the time to talk with people and lacked warmth and empathy.
- We saw one staff member approached a person who was sitting in a wheelchair at the table. The staff member pulled the wheelchair backwards and then started to lift the person's feet onto the footplates without saying a word to the person. The person was startled and shouted out and then the staff member explained what they were doing.
- Relatives said the staff were kind. Comments included; "They [staff] are always pleasant and friendly when we visit" and "There are one or two male staff who are so enthusiastic about the residents and I believe genuinely care."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not maintained and staff did not always treat people with respect.
- People were not offered choices. We saw a staff member giving out morning drinks of tea and coffee, no one was asked what they wanted, the drink was just put in front of them. At lunchtime meals were brought out already plated and no one was asked what they wanted. Plates for food were not covered when staff were taking meals to people in their rooms.
- Bed linen and towels were thin and worn. A sheet on one person's bed had started to tear, the pillow was lumpy and the filling was coming out of the duvet.

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

The provider responded to the inspection findings and sent information to show they were taking action.

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

- People were not always involved in decisions about their care.
- Care records lacked evidence to show people had been involved in planning and making decisions about their care.
- One relative told us they had been consulted about their family member's care plan. However, other relatives said they had not been invited or involved in care planning or reviews.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

At our last inspection the provider had failed to ensure people received person-centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- People's care plans did not reflect their needs and were not accurate or up to date.
- Body maps for one person showed they had sustained skin damage yet this was not reflected in their care plans. Another person's records showed they were incontinent and wore pads. There was no reference to incontinence pads in their care plan and the continence assessment had not been completed.
- We saw one person was wearing slippers when walking with staff. Their care plan stated they needed to wear shoes not slippers, as they dragged their feet in slippers increasing the risk of falling.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's social care needs were not met.
- There was no planned activity programme and no activity co-ordinator. The provider advised entertainers visited the home on a monthly basis for singalongs.
- There were limited activities taking place when we visited the service. We saw staff threw and kicked a soft ball with some people and played a game of bingo with a few others. One person's care plan stated staff were to provide one-to-one activities to prevent isolation and loneliness as they stayed in their room. We saw no activities took place with this person.
- Some staff took time to chat with people. Yet we also saw people sitting for long periods of time without any stimulation or interaction from staff.
- People were supported to keep in touch with family and friends.

People were not receiving personalised care. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the inspection findings and sent information to show they were taking action.

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.

● People's communication needs were met.
● Care plans provided information about people's communication needs.
● A pictorial guide was available to help people chose food and drink, however, we observed this was not used.

Improving care quality in response to complaints or concerns
● A pictorial complaints procedure was displayed in the entrance to the home. However, this did not give any timescales for the process.
● The manager said there had been no complaints and stated there were no complaint records.
● People and relatives told us if they had any concerns they would raise these with the staff.

End of life care and support
● Care plans were in place for people who were receiving end of life care. These provided information about their wishes and preferences as they approached the end of their life and the arrangements after they had died.

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 inadequate. The rating for 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.

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

At our last inspection the provider had failed to ensure robust systems were in place to assess, monitor and improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Significant shortfalls were identified at this inspection with similar concerns to those found at our previous inspection. There were continued breaches in relation to safe care and treatment, staffing, recruitment, person-centred care and dignity and respect and a new breach in relation to safeguarding. These issues had not been identified or addressed through the provider's own governance systems.
● Following the first day of our inspection we informed the provider of our concerns and requested a response detailing the action they would take to ensure people were safe. We made referrals to the local authority safeguarding team. The provider sent an action plan which provided assurances. When we returned on the second day some issues had been addressed but further issues were identified.
● There was a lack of consistent and effective management and leadership. Since the registered manager left in April 2019 there have been four managers none of whom have registered with CQC. The manager at this inspection started in post in March 2022 and was in the process of applying for registration with CQC. Staff said the manager was supportive and keen to make improvements.
● Quality audits were not effective in identifying or securing improvements. For example, monitoring and analysis of accidents and incidents was inaccurate. The manager said no accidents or incidents had occurred in July 2022 yet care records show two people had fallen. Care records showed two incidents in May 2022 yet these were not recorded on the accident log or included in the monthly analysis. Maintenance issues were not identified or addressed this included broken furniture, a shower not working, cleaning solution not stored safely and bed rail checks not in place.
● Provider oversight and monitoring was ineffective in identifying and managing organisational risk. Provider visit reports were completed however these failed to identify or resolve the issues we found at the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider engaged with people and staff however this failed to drive improvement at the service.
● Relatives were generally satisfied with the care provided, although one commented on the changes in management saying, "The only concern I have is the manager's role. It seems to change person every six months or so." Three relatives stated they would recommend the service.
● A residents meeting had been held in June and July 2022. Notes from the June meeting showed one person had asked for something different for tea instead of the same sandwiches all the time. Our discussion with the cook showed sandwiches were served for tea every night with the same choice of fillings.

● A staff meeting held in June 2022 raised issues such as repositioning charts not being completed and staff who had not seen what people had eaten and drunk completing food and fluid charts. Our inspection highlighted the same concerns showing these issues had not been addressed.
● Surveys had been completed by relatives and all expressed satisfaction with the service.
● Staff surveys had also been completed and made many suggestions about how the service could be improved such as more activities for people, better communication and maintenance works.

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

The provider responded to the inspection findings and sent information to show they were taking action.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager understood the requirements of the regulations to make notifications and to comply with duty of candour responsibilities when things had gone wrong.

Working in partnership with others
● Care records showed the service worked in partnership with health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person-centred care based on their needs and preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment, risks to people's health and safety were not assessed and mitigated. Medicines were not managed safely. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse or improper treatment. Regulation 13 (1)

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

personal care	governance The provider failed to ensure robust governance systems were in place to assess, monitor and drive improvement in the service and to assess, monitor and mitigate any risks to people. Regulation 17 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to implement robust recruitment processes. Regulation 19 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of staff to meet people's needs. Regulation 18 (1)