

Speciality Care (Rehab) Limited

Rosehill Rehabilitation Unit

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Rosehill Rehabilitation Unit is a residential care home providing personal care and rehabilitation care for people who have acquired a head injury and neurodisability. The service is registered to accommodate up to 16 people. At the time of the inspection there were eight people living at the service.

People's experience of using this service and what we found

People were not always supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible; however, the systems in the service did not always support this practice. Mental capacity assessments had not always been completed. Where decisions had been made for people, there were no records that best interests' meetings had taken place with relevant people to discuss if the decision was in the person's best interests. This was immediately addressed and records were in place before the end of the inspection.

People had individualised care plans, which detailed the care and support they needed. This ensured staff had the information they needed to provide person-centred support for people. However, due to vacancies within the multidisciplinary team, some people were not receiving the ongoing rehabilitation people needed to move forward and the service was not delivered its purpose, of enabling and empowering people in their recovery. Staff expressed concern about this.

There were systems in place to check the quality of the service. However, internal audits and processes failed to identify or address the issues we found at this inspection.

Staff told us they were well supported by the manager and deputy manager of the service. Some staff told us they did not feel supported or valued by the provider. We spoke with the regional director who said they would meet with staff to discuss their concerns.

Staff were kind and caring. They had a good understanding of people as individuals, their needs and interests. Most people needed some support with communication and were not able to tell us their experiences; those who could told us they were happy, and we observed that people were happy and relaxed with staff.

There were enough staff who had been appropriately recruited, to meet people's needs. Staff understood what they needed to do to protect people from the risk of abuse.

Risks associated with people's individual health and care needs were now assessed and guidance was available to staff on how to minimise known risks to keep people safe. Incidents and accidents were well managed. People's medicines were managed safely.

Staff attended regular training to update their knowledge and skills and had opportunity to reflect on their practice through regular supervision meetings.

People were supported to attend health appointments, such as the GP or dentist and attended appointments for specialist advice and support when needed. People had enough to eat and drink and menus were varied and well balanced.

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 requires improvement. (published 31 July 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection although some improvements had been made, the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for two consecutive inspections.

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

We found three breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we asked the provider to take at the back of the report.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good ●

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Details are in our well-led findings below.

Rosehill Rehabilitation Unit

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

One inspector and one 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:

Rosehill Rehabilitation Unit is a residential home that is registered to provide accommodation and personal care to a maximum of 16 people. At the time of our inspection, eight people were living there. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager. The manager was in the process of applying with the Care Quality Commission to become the registered manager of 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.

Notice of inspection:

This inspection was unannounced.

What we did:

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about and we sought feedback from the local authority and professionals who work with the service.

During the inspection, we spoke with five people who used the service, and one visiting healthcare professional to ask about their experience of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 12 staff including the manager, deputy manager, quality improvement lead and operations director. After the inspection we spoke with two relatives and a health care professional to gather their views about the service.

We looked at five care records in relation to people who used the service. We reviewed medicine administration records, three staff files as well as records relating to the management of the service, recruitment, policies and systems for monitoring quality.

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. At this inspection this key question has now improved to good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

At our previous inspection in June 2018, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always protected from risks because records were incomplete and did not always provide sufficient information to staff on how to manage risks. At this inspection we found sufficient improvement had been made.

- Risks to people's safety and wellbeing were now fully assessed and managed. Each person's care plan included risk assessments considering risks associated with the person's environment, their care and treatment, medicines and any other factors relating to their care and support. The risk assessments were detailed and included actions for staff to take to keep people safe and reduce the risks of harm. One staff member told us, "I believe all the residents are safe here. We are all aware of who presents a safety risk with choking, diabetes, falls and we're well briefed on the behavioural risks of some residents. There's definitely a safety culture here."
- Where people experienced periods of distress or anxiety staff knew how to respond effectively. A relative told us, "Staff are amazing. It's been the best place for [name]. they try and find innovative ways to manage her behaviour. I know that she is safe and secure."
- There were certificates in place for the electrics, gas, fire alarm and moving and handling equipment to verify their safety. The service was well maintained.
- People had personal emergency evacuation plans in place. These plans provided staff and emergency personnel with important information about the support each person required in an evacuation.

Systems and processes to safeguard people from the risk of abuse

- People who could, told us they were safe living at the service. A relative told us, "I'm happy as I know [name] is safe and secure."
- People continued to be protected from abuse and avoidable harm.
- Systems were in place to safeguard people, staff had regular safeguarding training and knew about the different types of abuse. Staff knew how to protect people from abuse and when concerns should be raised with the manager and the provider. One staff member told us, "I would report any abuse straightaway" and added that if no action was taken, "I would go to CQC or the local authority."
- There was information about reporting safeguarding appropriately displayed in the service to provide guidance to staff.

Staffing and recruitment

- There were sufficient numbers of staff to meet people's needs. Staff were available to people throughout the day, had time to spend with people and were visible in communal areas of the service.
- Staffing needs were calculated on individual needs assessments, which were reviewed and updated regularly as people's needs changed. Staff told us there were enough staff for the number of people currently living at the service.
- The provider's recruitment policy ensured as far as possible that new staff were suitable to work in the service. Records showed that appropriate checks were in place before staff started work.

Using medicines safely

- Medicines were managed safely to ensure people received them safely and in accordance with their health needs and the prescriber's instructions. Staff were trained in medicines management and regular competency checks were carried out to ensure safe practice.
- Some people had been prescribed medicine to be used as required (PRN). There were clear protocols for staff to follow before administering these.
- People's medicines were safely received, stored and administered. Storage temperatures were monitored to make sure that medicines would be safe and effective. Medicines were audited regularly with action taken to follow up any areas for improvement.
- Staff recorded when medicines were administered to people on medicines administration records and these were found to be accurate.

Preventing and controlling infection

- Staff had completed infection control training and followed good infection control practices. They used protective clothing gloves and aprons during personal care to help prevent the spread of healthcare related infections.
- The service was clean and odour free. Bathrooms and toilets held hand wash liquid and disposable paper towels, there was also hand sanitizer available around the service to use to reduce the risks of cross infection.

Learning lessons when things go wrong

- The provider had systems to audit all accidents and incidents which occurred and acted to minimise further risks to people.
- The provider learnt from incidents and good practice was shared within the company, so lessons could be learnt across the providers locations.

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. 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

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.

- Mental capacity assessments had not always been completed to establish if people were able to consent to their care and treatment. For instance, for medicines managed by staff or the use of alarm mats and alarms on doors to keep people safe.
- Some people lacked capacity to make some decisions for themselves. Staff told us and we saw, decisions had been made in people's best interests to keep them safe and promote their wellbeing but we found these had not been recorded as they should. For example, one person liked to smoke. Their care plan said following discussions with their family, it was decided there should only be one packet of cigarettes on the unit at any one time. If the person wanted to smoke more, staff would support them to go out and buy more cigarettes, in order to promote the person's independence and mobility. However, there was no evidence that a best interests decision making process had been followed involving, for example, staff, family, and appropriate healthcare professionals, to ensure this decision had been made appropriately, was the least restrictive option, and was in their best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our findings with the manager who told us prior to the inspection the records we looked at did have the appropriate MCA and best interests decision records in place. They acknowledged that they were

not there when we reviewed the records. This was immediately addressed and records were in place before the end of the inspection.

- The manager had made DoLS referrals where people's liberty was being restricted and had met the conditions of authorisations.
- Staff understood the principles of the MCA and knew how this applied to supporting people. Staff asked people for their consent before they supported them.

Staff support: induction, training, skills and experience

At our previous inspection in June 2018, we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not always completed training or received training in subject's related to people's specific needs. At this inspection we found sufficient improvement had been made.

- Staff had received training the provider had deemed to be 'mandatory', in subjects such as, fire safety, first aid, manual handling, safeguarding and data protection and confidentiality. Staff received protected training time and we found at this inspection the service was meeting the provider's targets, with 94% of staff completing their mandatory training.
- Some specific training to meet the needs of people living at the service was provided. For example, some staff attended end of life training with the local hospice and end of life training was included in the providers training programme for all other staff.
- During the inspection the manager received authorisation from the provider to source specific training to meet the needs of people living with an acquired or traumatic brain injury.
- The manager told us training provision at the service was continually monitored and they had worked hard to ensure staff received the training they needed.
- Staff told us they received supervision and felt supported by the manager and deputy manager.

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

At our previous inspection in June 2018, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's care records did not always demonstrate they were being supported to eat and drink enough to maintain a balanced diet. At this inspection we found improvements had been made.

- Meal times were a social and positive occasion and people were offered a choice of meals and where they could eat their meal, for example, in their room, the dining room or on the sun terrace. We saw people appeared to be enjoying their meals and people confirmed this by saying "Yes" when we asked if they liked the food.
- Where people required assistance, this was done respectfully and at the person's own pace.
- People's dietary needs, including specialist diets, were assessed and managed effectively by staff.
- Where there were risks of people not eating enough, records were kept to monitor what they had consumed and we saw action was taken, such as, referrals made to dieticians, if people were not eating enough or had lost weight.
- Staff monitored people's weight and people received dietary supplements and a high calorie diet when required, to help prevent weight loss.

- Staff continuously encouraged people to drink and people at risk of dehydration, had their fluid intake monitored and recorded to ensure they were drinking enough. One relative told us they looked at their relative's food and fluid charts during every visit, and always found them to be completed and up to date. They said, "It's reassuring to see that [name] is getting the care they need."

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

- Before people started using the service, their needs were assessed. This informed the care plan and assured the service that they could meet people's individual needs.
- People and their relatives and/or representatives where appropriate, were included in the assessment process to ensure that as much information was gathered about the person and their specific needs as possible.

Staff working with other agencies to provide consistent, effective, timely care

Supporting people to live healthier lives, access healthcare services and support

- People had access to healthcare services and professionals according to their needs. These included their GP, district nurse, dietician and speech and language therapist (SALT). People could access optician and dental visits.
- The service worked positively with health and social care professionals to help ensure people received effective care and treatment. For example, a visiting health care professional told us about how staff diligently followed guidance and instructions in order to help one person's skin heal. The health professional told us, "They put [name] on an airwave mattress without me having to ask, and their skin is lovely now. You don't need to ask for help, they know what I need and just get it for me. It's always a pleasure to come here."

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

- People lived in a service which had been suitably adapted to meet people's individual needs.
- People who used wheelchairs could access other floors of the building through the lift and people were able to walk around with or without staff support as needed.
- People's rooms were personalised to their taste and they had personal items in their bedrooms.
- A lift provided access between floors and there was some signage to help people orientate around the building.

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People smiled and nodded their heads when we asked them if they liked staff and if they were kind to them. Relatives were positive about the care staff gave their family members. One relative told us, "All the staff are lovely, and they care for [name] a great deal. [Name] is living in a place where she is happy and loved."
- People received care from staff who developed positive, caring and compassionate relationships with them. We observed many caring interactions, and conversations between people and staff were respectful and warm. For example, when one person became anxious at lunchtime, staff spent time talking with the person, providing reassurance and support during their meal. This helped them, and we saw they became visibly happier and calm. Staff clearly cared for the person and provided support tailored to their needs.
- Staff had time for people, both in meeting their immediate and basic care needs, and to socialise and spend time with them.
- People were supported by staff who knew their backgrounds and life history. The service aimed to gather as much information as possible about people and their lives, including their likes and dislikes, cultural and spiritual needs and what was important to them. A relative said, "They know her so well, they know her ways and they like her. I'm happy she's getting the physical care, but they also give her the emotional care she needs."

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

- People's communication needs were known, recorded and understood by staff. Staff could describe the support people needed to enable staff to understand their wishes and support their decision making.
- Where people could not communicate their views or concerns, staff would observe their facial expressions, changes in behaviours and body language to gauge their views, needs or if someone was in pain or discomfort. We observed staff positioned themselves at eye level and used reassuring touch, where it was appropriate.
- People were at the centre of their care and where possible were supported to make decisions, as well as being involved in reviewing their own package of care. One person told us, "You choose your bedtime or getting up at breakfast."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was respected by staff. Staff told us how they respected people's dignity, for instance, making sure they were covered up during personal care and how important it was to make sure they were comfortable with what was happening. One staff member told us, "I know that it's really important I explain what I am going to do, such as when I'm giving personal care. It's not very nice for someone to just do something to you, like wash you, when you're not expecting it. That doesn't show respect."
- Staff ensured people's personal spaces were always respected. For example, knocking on bedroom doors before entering and by talking and engaging with people before assisting them, whether with their meals or their mobility.
- Staff understood how to assist people and promote their independence. Staff explained they treated everyone as an individual and understood how much each person could be involved or do for themselves.

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. 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

At our previous inspection in June 2018, we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's care records were not always detailed, and people's end of life preferences were not always known. At this inspection we found some improvements had been made, however some improvements were still required.

- People received a pre-assessment prior to moving into the service, to help ensure their needs could be met. However, staff told us due to vacancies within the multidisciplinary team, staff were having to request input and support from local community teams for people who required occupational therapy (OT) and speech and language therapy (SALT). This support was very limited and did not provide the ongoing rehabilitation some people needed to move forward. Staff expressed concern about this, one said, "They're [people] pretty much all static in their conditions, with some even at risk of regression, simply because we don't have the resources to help them get any better." We spoke with the manager about what we had been told they confirmed the provider were not currently recruiting for these positions and acknowledged the lack of in-house resources had prevented some people from progressing and moving on. This meant Rosehill Rehabilitation Unit was not delivering its purpose, of enabling and empowering people in their recovery.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were passionate about delivering personalised care and treatment to help ensure effective outcomes for people.
- People had individualised care plans, which detailed the care and support they needed and included key information on their likes, preferences and hobbies. This ensured staff had the information they needed to provide person-centred support for people.
- People were encouraged to be involved in developing their care and treatment plans including setting their own goals and how these were going to be achieved. People who were unable to participate in their own care planning, staff involved their families and health professionals.

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 included people's communication needs and how their needs should be met.
- Care plans included guidance on whether people needed glasses or hearing aids and how they needed to be maintained. Pictorial signage was used to improve communication and understanding.
- Staff recognised and identified people's communication needs. Staff told us how they observed body language and how some people required clear and simple instructions. One staff member said, "The way we listen to the residents that can communicate is done with empathy. We know our residents well, and we make sure we tailor what we do to what they need."

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 were supported in activities of their choice and which were of personal interest to them. All group and community activities were planned to meet individual preferences and needs.
- Social stimulation included activities that promoted physical health such as swimming, activities to promote daily living skills such as shopping and activities that promoted wellbeing such as music, movie sessions and animal visits.
- During the inspection we observed many spontaneous activities instigated by staff. Staff used their initiative and were highly motivated. We saw staff using every opportunity to get people involved in activity, such as a game or quiz or even just simply sitting with people and talking. One member of staff told us, "We focus on giving each resident a great day, with personal care that's all about them."

Improving care quality in response to complaints or concerns

- The provider had a complaints policy and procedure in place. Details were displayed throughout the service.
- Records of complaints showed that all complaints had been investigated and responded to in line with the providers policy.
- Relatives told us they felt they could raise any concerns and they would be dealt with in a timely manner. One relative told us, "if I have any queries I ring up or just tell them when I visit and they do put things in place to correct it."

End of life care and support

- At the time of our inspection no one living in the service was receiving end of life care.
- Where appropriate people were involved in their end of life care planning. People's care plans identified their wishes in relation to their end of life care and included specific requirements relating to cultural needs.
- The manager told us that they worked closely with external healthcare professionals to respect people's wishes and provide them with the care they required to be pain free and cared for at the end of their life.
- Staff received training on caring for people at the end of their lives.

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 requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

In June 2018 the provider had failed to have robust systems in place to manage the service. The provider submitted an action plan to CQC in July 2018 to advise of the improvements they planned to make to the service. At this inspection although some improvements had been made, the provider was still in breach of regulations.

- The provider did not have effective systems and procedures in place to ensure the safety and quality of the service.
- Following the last inspection the management team had implemented a range of quality assurance systems to enable the provider and manager to monitor and improve the quality of the service. This included quality walk around by the manager and provider's representative and monthly audits such as audits of care plans, medicines and staff training. However, governance systems and processes failed to identify or address the issues we found at this inspection; such as, issues related to meeting people's needs or meeting the requirements of the Mental Capacity Act 2005.
- The providers had not done everything possible to maintain the multidisciplinary team. This meant that people's rehabilitation requirements and needs were not always met, resulting in a lack of opportunity to maximise their independence and progress to lead a fulfilling life.

This is a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities).

- Since our last inspection the provider had appointed a new manager who was applying to be the registered manager of the service. The manager told us they had received a full induction to their role and were supported by a deputy manager, quality improvement lead and operations director.
- Since taking up their position, the manager told us they had been focusing on the action plan from the previous inspection. The manager acknowledged some of their auditing processes needed strengthening.
- The manager had undertaken a review to see if the service could be improved to support people requiring ongoing care and rehabilitation better. The assessment of the delivery of this service and how it could be improved, was continuing.

- Notifications of important events were submitted to CQC as required.
- The provider had displayed their Care Quality Commission (CQC) assessment rating at the service.

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

- Staff spoke positively about the manager and deputy manager, and felt respected, supported and valued by them. However, some staff told us they did not feel supported or valued by the provider and felt the provider was not putting the needs of the people living at the service, first. For example, staff were concerned that vacant multidisciplinary team posts had not been filled which they felt had impacted upon people's rehabilitation. We brought this to the attention of the operations director who was unaware of staffs' concerns and assured us he would meet with staff to discuss the issues raised.
- Regular staff meetings took place to enable staff to receive updates and raise issues for discussion.
- People and their relatives were encouraged to provide their views on the running of the service. Satisfaction surveys were sent out and the manager regularly met or contacted relatives by email or telephone to discuss any concerns or queries.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff were passionate about ensuring people's needs were met and making sure they were empowered.
- People's relatives and health professionals we spoke with told us they felt the manager and staff were person-centred in their approach. One relative said, "They manage [name] extremely well. They are responsive and have his best interests at heart and they are proactive in seeking out the care and input he needs."
- Staff knew about how to whistle-blow and raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon.

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 of their duty of candour requirements and records showed the service investigated issues and concerns and acted appropriately. Complaints, incidents and accidents were used to drive improvement and learn from. The duty of candour sets out actions that the registered manager should follow when things go wrong, including making an apology and being open and transparent.

Working in partnership with others

- People's health and welfare needs were met by a range of local healthcare providers, social work teams and community services.
- Records showed that staff supported people to access healthcare appointments to maintain their wellbeing.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider was not doing everything reasonably practical to make sure that people received care and treatment that met their assessed needs. The provider was not delivering its purpose, of enabling and empowering people in their recovery.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>People's rights were not consistently being upheld in line with the Mental Capacity Act (MCA) 2005.</p> <p>Where a person lacked mental capacity to make an informed decision, or give consent, staff did not always act in accordance with the requirements of the MCA and the associated code of practice.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not always effectively operate systems and processes to assess, monitor and improve the quality and safety of the service.</p>