Avery Homes (Nelson) Limited

Elvy Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Elvy Court Care Home is a residential care home with nursing for 55 older people and younger adults who have physical adaptive needs or who live with dementia. It can also accommodate people who have sensory adaptive needs.

At the time of this inspection there were 49 people living in the service of whom 34 lived with dementia. Some people had special communication needs.

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

People's experience of using the service and what we found:
This inspection was prompted by video evidence received by the local safeguarding of adults authority. The authority concluded the evidence showed that a person living in the service had experienced physical abuse due to rough treatment and emotional abuse. The authority also found the evidence showed that the same person had not consistently received safe care and treatment. This was because they had not been correctly assisted to change position when in bed. This had increased the risk of them developing sore skin. Also, they had not been safely supported to drink to reduce the risk of them choking. These shortfalls had contributed to the person not receiving a caring and person-centred service. Given these issues there were also concerns about how well the registered persons were monitoring and evaluating the running of the service.

The local safeguarding of adults authority asked the registered persons for immediate assurances that suitable steps had been taken to protect the person from the risk of further abuse and unsafe care. A decision was made for us to inspect the service to ensure that people were kept safe and that risks to their health and safety were reduced. As a result we undertook a focused inspection to review the key questions 'safe', 'caring' and 'well-led' only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. Therefore, we did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

People and their relatives were positive about the service. A person said, "I'm good here and the staff are lovely to me." Another person said, "No complaints from me as I have everything I need." A relative said, "I chose this place because it has a homely atmosphere. And that's what it is – a home from home where the residents come first."

However, we found that the registered persons need to make further improvements. We noted that after the registered persons received the video evidence they had quickly taken action designed to keep people living in the service safe. This was so that all the people living in the service were safeguarded from the risks of abuse and unsafe care and treatment. Nevertheless, in practice some of the steps taken had not been well organised and did not provide a comprehensive response. Although this oversight had not resulted in

people experiencing direct harm or unsafe care it had increased the risk of this occurring. It had also increased the risk of people not experiencing a caring and person-centred service that promoted their dignity.

During the inspection visit we raised these concerns with the registered persons. They assured us that steps would immediately be taken to address each of them. Soon after the inspection visit the registered persons sent us information confirming that our concerns had been addressed. They said that suitable quality checks had been put in place designed to ensure people were robustly protected from the risk of abuse and unsafe care and treatment. This was so they received a caring service that promoted their dignity. However, we need to be to assured that these quality checks will be sustained and will result in people consistently receiving safe care.

Our other findings were as follows:
Regulatory requirements had not been met.

Nurses and care staff had the knowledge and skills they needed. They assisted people to manage healthcare conditions in the right way.

People were supported to use medicines safely.

There were enough nurses and care staff on duty and safe recruitment practices were followed.

Lessons had been learned when things had gone wrong such as accidents, falls and near misses.

Good standards of hygiene had been maintained to prevent and control the risk of infection.

When people received care their right to privacy was respected and they were supported to make decisions about things that were important to them.

Confidential information was kept private.

People had been consulted about the development of the service.

Joint working was promoted.

Enforcement:
We have identified breaches of regulations in relation to safeguarding people from the risk of abuse and protecting people from unsafe care and treatment. There was also a breach of regulations in relation to the systems and processes used to monitor and evaluate the running of the service.

Please see the actions we have told the registered persons to take at the end of this report.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit in line with our re-inspection programme. If any further concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Elvy Court Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the registered persons were meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the service on 10 July 2019.

Inspection team:
The inspection was completed by one inspector.

Service and service type:
Elvy Court Care Home is a residential care home with nursing for 55 older people and younger adults who have physical adaptive needs or who live with dementia. It can also accommodate people who have sensory adaptive needs.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Notice of inspection:
This inspection was unannounced.

What we did before the inspection:
We used video evidence we had received from the local safeguarding authority. The evidence showed that a

person had experienced physical and emotional abuse. It also showed that they had not always received safe care and treatment in line with national guidance.

We used information the registered persons sent us in their Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection on 30 May 2019. These are events that happened in the service that the registered persons are required to tell us about.

We invited feedback from the commissioning bodies who contributed to purchasing some of the care provided by the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes. This information helps support our inspections.
We spoke with seven people living in the service using sign-assisted language when necessary.

During the inspection:
We spoke with five care staff, two senior members of care staff and two nurses. We also spoke with the deputy manager, registered manager and regional support manager. In addition, we met with the regional manager to whom the registered manager reported.

We reviewed documents and records that described how care had been planned, delivered and evaluated for six people. This included the person who had been subjected to physical and emotional abuse and who had not consistently received safe care and treatment.

We examined documents and records relating to how the service was run. This included the actions taken by the registered persons when responding to the abuse and unsafe care experienced by a person living in the service. We also looked at other documents and records relating to health and safety, fire safety, management of medicines and the deployment of staff.

We reviewed the systems and processes used by the registered persons to assess, monitor and evaluate the service.

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 cannot talk with us.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection on 30 May 2019 this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to support staff to keep people safe from harm and abuse;
• People had not been consistently safeguarded from situations in which they may be at risk of experiencing abuse. In particular, there had been a number of occasions when a person had experienced physical abuse due to rough treatment and emotional abuse. The perpetrators were four members of care staff who mainly worked at night. As soon as the matter came to the attention of the registered persons the perpetrators were suspended from duty. By the time of our inspection visit they had been dismissed from their employment.
• The registered persons had also quickly taken other steps designed to ensure that all remaining nurses and care staff were working in the right way to keep people safe. These actions included senior members of staff personally supervising the provision of care to assess how well it was being delivered in practice.
• We were told that a further measure had involved all nurses and care staff meeting with a senior colleague. This was so they could receive additional guidance about their duty to immediately 'whistle-blow' any concerns they may have about the care being provided in the service. However, this action was not well organised because there was not an accurate record of which members of staff had received the guidance. This increased the risk that mistakes would be made leading to individual members of staff being overlooked. We raised our concerns about this matter with the registered manager and regional manager who assured us that the oversight would immediately be put right. Shortly after our inspection visit they sent us evidence confirming that our concern had been addressed.
• The regional manager told us that as a further precaution all care provided in the privacy of people's bedrooms was being delivered by two care staff. They said this would be the case regardless of whether two staff were actually needed to provide the care in question. They informed us that the new arrangement would ensure that each member of staff was supervised by a colleague to ensure that people were kept safe. However, we found that this measure was not well organised and as a result was not always being followed. We raised our concerns about this matter with the registered manager and regional manager. They immediately began reviewing their plan to find out why it had not been fully implemented. Shortly after the inspection visit they confirmed to us that the new arrangement was in place and that its operation was being carefully reviewed.

Failure to protect a person from physical abuse through rough treatment and emotional abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management:
• Risks to people's safety had not always been assessed, monitored and managed so they were supported to

stay safe while their freedom was respected. Video evidence showed that a person had not been helped in the right way to drink from a cup. This was because they had not been helped by two different care staff who were no longer employed in the service to sit in an upright position so there was less risk of them choking. Also, the same person had not been supported to change position in bed in a way that ensured their safety and comfort. This was because two former care staff had partially dragged the person under their arms when assisting them to change position. They had not used a special low-friction sheet that is designed to reduce the risk of a person's skin being chaffed and becoming sore.
• The registered manager and regional manager told us that immediately after seeing the video evidence they had taken steps to put things right. We found that they had reviewed the guidance provided for nurses and care staff when assisting people to eat, drink and change position in bed. They had done this to ensure that the information provided in relation to each person was correct. They had also arranged for senior colleagues to observe how the assistance in question was provided. This was so that any problems could quickly be addressed.
• Furthermore, the regional manager had arranged for the Avery Learning and Development Director to call to the service. The consultant was present during the inspection visit. They told us they were providing all nurses and care staff with additional training in safeguarding people from abuse and how to correctly support people to drink safely. Also, how to help people change position in bed by using equipment such as slide sheets. They were also assessing the competencies that nurses and care staff had acquired to ensure they were working in the right way.
• We examined the guidance provided for nurses and care staff for four people who needed help to eat, drink and change position in bed. We found the guidance to be accurate and comprehensive. We asked four care staff and one nurse about this aspect of their work and found that they knew how to correctly deliver the care in question. In addition, we saw five people being assisted in the right way to eat and drink and two people being assisted correctly to change position when in bed.

Failure to protect a person from the risk of unsafe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were being supported in the right way to manage other risks to their health and safety. When necessary people had been provided with pressure relieving mattresses that were correctly inflated. These provide a soft surface that makes it less likely a person will develop sore skin. Also, nurses had applied creams and protective dressings in the right way when a person's skin was becoming sore. Nurses and care staff also assisted people in the right way to promote their continence. We observed nurses regularly changing catheter bags, using the correct catheter bags and carefully checking that people had not developed a urinary infection. A person said. "I get all the help I need here and the staff don't mind doing it."
• People had been helped to avoid preventable accidents. Hot water was temperature-controlled and radiators were fitted with guards to reduce the risk of scalds and burns. Windows were fitted with safety latches to prevent them opening too wide so they could be used safely.
• The service was equipped with a modern fire safety system. This was designed to enable a fire to be quickly detected and contained so people could be moved to safety. The fire safety system was being regularly checked to make sure it remained in good working order. Nurses and care staff had been given guidance and knew how to quickly move people to a safe place in the event of the fire alarm sounding.

Using medicines safely:
• People were helped to safely use medicines in line with national guidelines. There were suitable systems for ordering, storing, dispensing and disposing of medicines. The deputy manager who was a nurse was responsible for the management of medicines in the service.
• There were robust arrangements to order medicines from the pharmacist. This involved the deputy manager checking the medicines held in stock for each person. This enabled them to identify if any items

were running low so they could be re-ordered in plenty of time for a new supply to be delivered to the service.
• Medicines were stored correctly in clean and secure treatment rooms. The treatment rooms were air conditioned so medicines were kept at the right temperature. Medicines that required cool storage were kept in special refrigerators.
• Nurses and senior care staff had received training and had been assessed to be competent to safely support people to take medicines. There were guidelines for nurses and senior care staff to follow about when and how each person needed to be offered the medicines that had been prescribed for them. Nurses and senior care staff followed these guidelines and helped people to take medicines in a safe way. A person said, "The staff give me my tablets like clockwork so I don't get muddled up."
• There were additional guidelines for nurses and senior care staff to follow when dispensing variable-dose medicines. These are medicines that a doctor had said can be used when necessary. An example of this was medicines used to assist a person when they became upset and needed extra help to be reassured.
• The registered manager had sought advice from a healthcare professional when a person had experienced difficulties swallowing tablets. This had resulted in the person's medicines being prescribed in a liquid form that was easier for them to swallow.
• Nurses and senior care staff completed an accurate record of each occasion on which they assisted a person to take medicines.
• The registered manager had regularly audited the systems and processes used to order, store, dispense and administer medicines. This was to check that medicines were consistently being managed in the right way.

Staffing and recruitment:
• Sufficient nurses and care staff were routinely on duty to provide people with the assistance they needed. We saw people promptly being assisted to undertake a range of everyday activities. This included using the bathroom, going to and from their bedroom and spending time in the communal lounges. A person said, "When I use my call bell the staff come pretty much straight away. The staff work hard but they get around to us all."
• Safe recruitment and selection procedures were in place. Applicants were required to provide a full account of previous jobs they had done. This was so the registered manager could identify what assurances needed to be obtained about applicants' previous good conduct.
• References from past employers had been obtained as had disclosures from the Disclosure and Barring Service. These disclosures establish if an applicant has a relevant criminal conviction or has been included on a barring list due to professional misconduct. All these checks helped to ensure that only trustworthy and suitable people were employed to work in the service.
• Additional annual checks were completed to ensure that nurses remained registered with their professional body. This was to ensure they continued to be authorised to complete clinical nursing procedures.

Preventing and controlling infection:
• There were suitable measures to prevent and control infection. There was written guidance for nurses and care staff to follow to reduce the risk of infection. They had received training about the importance of good hygiene and knew how to put this into practice. A relative said, "This place is spotlessly clean."
• Nurses and care staff had been provided with uniforms. We saw that all members of staff were neatly dressed in clean uniforms.
• Nurses and care staff had been provided with antibacterial soap. We saw them regularly washing their hands. They also wore disposable gloves and aprons when providing people with close personal care.
• There was an adequate supply of cleaning materials. Fixtures, fittings and furnishings were clean. In addition, mattresses, bed linen, towels and face clothes were clean. This was also the case for tablecloths,

drinking glasses and cutlery.
• The registered manager had completed regular and detailed audits to ensure that suitable standards of hygiene were maintained in the service.

Learning lessons when things go wrong:
• The registered manager and regional manager used an electronic audit tool to analyse accidents such as falls and near misses. This was so that lessons could be learned and improvements made. The audit tool contained information about what had happened and the causes so that trends and patterns could be seen. An example was the audit tool identifying the locations and times of day when people had fallen so the reasons for this could be identified.
• When accidents and near misses had occurred action had been taken to reduce the likelihood of the same thing happening again. This included consulting with a person's relatives and requesting assistance from healthcare professionals. An example was nurses arranging for a person to see their doctor if they appeared to have become unsteady on their feet due to being unwell. Another example was the registered manager seeking advice from an occupational therapist when it appeared likely that a person needed to use a different walking frame that better met their changing needs.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that people were supported and treated with dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to 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 and promoting people's privacy, dignity and independence:

• We found that people were not always treated with compassion. In particular, video evidence showed that one person had not been assisted in the right way by four former care staff to derive reassurance from holding personal keepsakes close to them. Also, there was evidence that the same former care staff had been disrespectful to the person. This was because they had repeatedly not asked the person if they wished to receive care before it was provided.

• The registered manager and regional manager told us that immediately after receiving the evidence they checked to make sure that both of these shortfalls had been resolved. They said that they had spoken with each nurse and member of care staff to establish that they recognised the importance of providing person-centred care. They also told us that senior colleagues had observed the provision of care. This was to ensure that the use of keepsakes was being promoted and that people were gently informed about the care they needed to receive.

• We asked three care staff about this matter and all of them appreciated the importance of people being supported to derive comfort from keepsakes. In addition, we saw three people who were cared for in bed holding and being comforted by keepsakes that nurses and care staff had carefully arranged on their beds. However, we needed reassurance that people would continue to be assisted to benefit from the use of keepsakes.

• We witnessed some occasions on which people were not fully supported to experience care that promoted their dignity. We were told that one person had declined assistance to maintain their personal hygiene. We were also told that the service was liaising with healthcare professionals for advice about how best to support the person. However, in practice no new steps had been taken to engage the person's interest in their personal hygiene. We saw the hair of this person and another person was very greasy and looked unkempt. Another person had not been quickly assisted to change their shirt after it had become stained with food.

• A fourth person had not been assisted to handle an everyday object in the right way. We saw the person attempting to use a piece of rolled-up paper to scratch their ear after which the paper was left in place as the person walked around the lounge. Although some care staff were present they did not offer to help the person remove the straw until we brought the situation to their attention.

• During the inspection visit we raised these concerns with the registered persons. They assured us that steps would immediately be taken to address each of them. Soon after the inspection visit the registered persons sent us information to show that our concerns had been addressed. They said that suitable quality checks

had been put in place to ensure people were robustly protected from the risk of abuse and unsafe care and treatment so they received a caring service that promoted their dignity. However, we need more assurance that the actions taken will be sustained and effective.

Failure to provide care that treated people with respect and promoted their dignity was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were positive about the care they received. A person who had special communication needs smiled and waved to a nearby member of care staff when we used sign-assisted language to ask them about their care. Another person said, "I like the staff and they're fine with me."
• A relative said, "I just can't fault them as the staff are kindness itself."
• Nurses and care staff were consistently courteous, polite and helpful. They addressed people using their chosen names and always gave people the time they needed to reply. They also chatted with people about the care they were about to be offered to seek their consent. An example of this was a member of care staff who showed a person who had special communication needs a mobile hoist. This enabled the person to indicate how they wished to be assisted to stand up from the armchair in which they were seated.
• People's right to privacy was respected and promoted. Nurses and care staff recognised the importance of not intruding into people's private space. People could use their bedroom in private whenever they wished. When providing close personal care nurses and care staff closed the door and covered up people as much as possible.
• Communal bathrooms and toilets had working locks on the doors.
• Nurses and care staff recognised the importance of providing care in ways that promoted equality and diversity. They had received training and guidance in respecting the choices people made about their identities and lifestyles. This included people who had been supported to meet their spiritual needs by attending religious ceremonies held in the service.

Supporting people to express their views and be involved in making decisions about their care:
• People had been supported to express their views and be actively involved in making decisions about their support as far as possible. An example of this was a member of care staff showing a person two different cardigans they often liked to wear. This was so the person could decide which garment they wanted to put on. We heard another member of care staff asking a person when they wanted to be assisted to go to the bathroom to wash. They also asked the person if they wanted to have a bath or a shower.
• All the people had family, friends, solicitors or care managers (social workers) who could support them to express their preferences. In addition, the registered manager had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to weigh up information, make decisions and communicate their wishes.
• Private information was kept confidential. Nurses and care staff had been provided with training and guidance about the importance of managing confidential information in the right way. Both the deputy manager and the registered manager asked to see our inspector's identification badge before disclosing sensitive information to us.
• Nurses and care staff only discussed people's individual care needs in a discreet way that was unlikely to be overheard by anyone else. A relative said, "The staff are very tactful and I've never heard them talking about something I shouldn't hear."
• Written records that contained private information were stored securely when not in use. Computer records were password protected so that they could only be accessed by authorised members of staff.
• Nurses and care staff knew about the importance of not using public social media platforms when speaking about their work.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement.

This meant the service's management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care;
• The registered persons had not established all the systems and processes that were necessary to operate, monitor and evaluate the operation of the service so that people consistently received safe care. Since our inspection in May 2019 and the registered persons' receipt of the video evidence of abuse and unsafe care, the registered persons had completed a number of quality checks. These were designed to ensure the service provided people with safe and person-centred care. The checks included auditing the records kept by nurses and care staff of the care provided for each person. The audits were intended to establish that care was being delivered in line with national guidance so that each person was assisted in the right way.
• The regional manager had reflected on the video evidence and had concluded that the service's quality checks needed to be developed further. This was so they focused more clearly on observing the care actually provided for people. They said this would reduce the likelihood of people being at risk of abuse and unsafe care when receiving assistance in private. The regional manager informed us that the new and more robust quality checks we have described earlier in this report under our key question 'safe' would be continued. They also emphasised that these new checks would concentrate upon observing the care provided for each person at different times of day and night.
• We concluded that the registered persons were taking sufficient steps to strengthen the systems and processes used to monitor the service to reduce the risk of people experiencing abuse and improper care so they were kept safe. However, we need more reassurance that the registered persons' quality checks will be maintained and will be effective. Therefore, we have rated this key question as, 'Requires Improvement'.

Failure to have robust systems and processes to operate, monitor and evaluate the running of the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• Nurses and care staff had not been fully supported to understand their responsibilities to meet regulatory requirements. They had been provided with written policies and procedures to help them to consistently provide people with the right assistance. They had also been provided with ongoing training and had met regularly with a senior colleague to receive advice and guidance. The regional manager said that in the light of the video evidence they had concluded that these arrangements on their own were no longer sufficient. They assured us that in future a much closer link would be established between the training and guidance

provided for nurses and care staff and feedback received from senior colleagues who had directly observed the provision of care. The regional manager said that any shortfalls in care delivery would more quickly be identified and would be robustly addressed through a member of staff receiving more detailed training and guidance.
• There was a senior member of staff on call during out of office hours to give advice and assistance to nurses and care staff.
• Nurses and care staff had been invited to attend regular staff meetings to further develop their ability to work together as a team. The regional manager was arranging for all nurses and care staff to attend an additional general staff meeting. This was so members of the staff team could receive information about the abuse and unsafe care a person had received. Also, so the registered manager could explain what steps were being taken to reduce the risk of the same thing happening again. The regional manager said that the additional staff meeting would be used to emphasise that there was an explicit 'no tolerance' approach in the service to any member of staff who did not treat people in the right way. The regional manager also assured us that all members of staff would explicitly be told that not reporting poor practice would be treated as a serious disciplinary matter.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• People and their relatives had been offered the opportunity to comment on their experience of using the service. The regional manager recognised that most of the people living in the service lived with dementia and had special communication needs. The regional manager said that this might make it difficult for most people to comment on their experience of receiving care and to contribute suggestions for the development of the service. In response to this the service had developed a tool that guided nurses and care staff to note both spoken and indirect feedback. An example of indirect feedback was nurses and care staff observing whether a person enjoyed particular meals so that as necessary changes could be made to the menu.
• Relatives had been regularly invited to meet with the registered manager and records showed that action had been taken when improvements had been suggested. An example of this was care staff being encouraged to car-share so there was more room left in the car park for use when relatives visited. A relative said, "In general yes I do feel listened to. Sometimes little niggly things aren't put right but overall there is an open atmosphere and the manager's easy to talk to and a lovely chap."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong:
• The instances of abuse and unsafe care we have described earlier in our inspection report showed that a person-centred and open culture had not been fully established in the service. The regional manager and registered manager assured us the actions they were taking to put things right would further develop a positive culture in the service. They said this would re-emphasise the duty of all members of staff to care for people in the right way. Also, for all members of staff to be alert to and immediately report examples of poor practice.
• The regional manager and the registered manager understood the duty of candour requirement to be honest with people and their representatives when things had not gone well. They had consulted guidance published by the Care Quality Commission. There was a system to identify incidents to which the duty of candour applied so that people with an interest in the service and outside bodies could reliably be given the information they needed.
• Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is so that we can check that appropriate action has been taken. The registered manager had submitted notifications to Care Quality Commission in an appropriate and timely manner in line with our guidelines. This included the registered persons' receipt in

July 2019 of information about the person noted above who had not been protected from abuse and unsafe care.
• It is a legal requirement that a service's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The registered persons had conspicuously displayed their rating both in the service and on their website.

Working in partnership with others:
• The service worked in partnership with other agencies to enable people to receive 'joined-up' support. The registered manager subscribed to a number of professional publications relating to best practice initiatives in providing people with nursing and personal care.
• An example of this was the regional manager and the registered manager knowing about important changes being made to strengthen the provision made to ensure people only receive support that is lawful and the least restrictive possible. This had enabled the registered manager and regional manager to anticipate the changes and ensure that the service was ready to implement them. Another example was the service participating in a university-based research project to identify new ways of engaging and promoting the independence of people who live with dementia.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered persons had failed to ensure that people were treated with respect and received care that promoted their dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to protect people from the risks of unsafe care and treatment.

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 The registered persons had failed to take robust steps to keep people safe from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to operate the systems and processes necessary to suitably monitor and evaluate the running of the service.