Pepperhall Limited

Valley Court

Inspection report

Valley Road
Cradley Heath
West Midlands
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Valley Court is a care home providing personal and nursing care to 67 older people at the time of the inspection, some of whom are living with dementia. The service can support up to 69 people.

Valley Court operates in a building that is designed to deliver care over two floors in three units.

People's experience of using this service and what we found
We received mixed feedback from people about feeling safe with the care and support they received. Some people told us they did not always feel safe. Risks to people's safety had not always been assessed and mitigated individually and within their environment. We received mixed feedback from people about staffing levels. Staff were aware of the procedure for reporting any concerns to help keep people safe. Although there were recruitment processes in place, we found that the process was not always followed, and pre-employment checks were inconsistent. Whilst some incidents and accidents had been recorded the service were unable to note trends that may be present in order to prevent comparable occurrences in the future.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Whilst staff told us they received regular training, the manager and the systems in place could not confirm this. Generally, people told us they enjoyed their meals but were not involved in the planning of the menus. People's health care records did not contain sufficient information and guidance for staff to follow.

People told us they were not always treated with kindness and compassion by staff who supported them. People were not consistently supported to make choices about their lives. We saw instances when people's privacy, dignity and confidentiality were compromised.

People did not receive personalised care that was responsive to their needs. People told us they did not contribute to the planning and reviewing of their care. People were given information in an accessible way, so it was easier for them to understand. People could not be confident that their wishes during their final days and following death would be understood and followed by staff.

The oversight and governance of the home was not always effective in resolving areas which required improvement. The audits and systems in place had failed to highlight a number of areas for action that were identified on inspection. People's experiences of the service were not consistently sought and feedback that was gathered had not been used to drive improvement. The provider did not carry out robust checks to ensure that care was being delivered safely and effectively.

Rating at last inspection
The last rating for this service was good (published 11 April 2017).

Why we inspected
This was a planned inspection based on the previous rating.

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

Enforcement
We have identified breaches in relation to safe care and treatment and the governance of the service. Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

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 always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement

Valley 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 Care Act 2014.

Inspection team
The inspection was carried out by one inspector, one assistant inspector, a specialist nurse advisor and an Expert by Experience. 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
Valley Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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 before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority, professionals who work with the service 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 with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 16 people who used the service and seven relatives about their experiences of the care provided. We spoke with 16 members of staff including the registered manager, deputy manager, qualified nurses, a nursing assistant, senior care workers, care workers, domestic and laundry workers, an activity coordinator and the cook. 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 reviewed a range of records. This included ten people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Following the inspection, the provider sent us an action plan and training information around fire safety to demonstrate actions being taken to improve service delivery.

Requires Improvement

Is the service safe?

Our findings

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

The last rating for this service was requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People were not protected from the risks associated with skin damage. One person's care plan indicated they were at high risk of skin damage. To mitigate this risk the person was prescribed topical cream to be applied to pressure areas twice a day. However, the registered manager told us, and records confirmed that the cream had only been applied once a day. Although the person had not developed sore skin, the shortfalls in question had increased the risk of this happening.

● People were not protected from the risks associated with malnutrition. We found that food and fluid monitoring charts had not always been completed fully. One person's care plan identified they were at high risk of malnutrition. The person's nutritional intake was not quantified, and their fluid intake was not calculated on a daily basis to ensure their nutrition and fluid intake was adequate to maintain their health. Poor risk assessing meant that the staff we spoke with were not aware of the person's targets for food and fluid intake. Although there was no evidence to show the person had experienced direct harm, the shortfall had increased the risk of this occurring.

●Risks to people had been assessed in relation to them as individuals. However, where people required the support of staff or equipment to mobilise, their care records did not contain guidance to direct staff how to safely support people to mobilise. For example, slide transfer sheets and wheelchairs.

●There were shortfalls in the steps taken to protect some people from the risk of fire. Although fire safety systems to detect and contain fire had been serviced, records showed staff who worked at the service had not taken part in fire drills. There had been specific recommendations made by the local fire and rescue service identified in March 2019. Fire drills are necessary so that care staff know what action to take if the fire alarm sounds.

●We highlighted these shortfalls to the manager. They assured us the oversights would quickly be put right and assured us that each of the shortfalls would immediately be addressed. After the inspection visit they sent us evidence to show that a number of improvements had been made or were underway to provide safe care and treatment.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care which placed people at risk of harm. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Most people told us they felt safe living at Valley Court. One person told us, "It's quite safe. At night some people walk about but that's about all." However, one person told us they did not feel safe which resulted in a safeguarding concern being raised promptly by the manager.

●The provider had a safeguarding process in place and made safeguarding alerts when necessary. Staff were knowledgeable about safeguarding and could explain the processes to follow if they had concerns.
● The service recorded some incidents and accidents, however had failed to effectively monitor these. This meant that the service was unable to note trends that may be present in order to prevent comparable occurrences in the future.

Staffing and recruitment
● People had mixed views about the staffing of the service. One person said, "Staff are always around and there when you press the call bell." However, other comments included, "The call bells are not answered quickly all the time. Weekends especially so." and "Sometimes you are kept waiting, the worst is when you are waiting to go to the toilet."
● Staff told us that if planned staffing numbers were maintained it was possible to meet people's needs, however they were often working with less than planned numbers due to sickness. One staff member said, "There are not enough staff and have too many agency staff." Another staff member told us, "Sometimes we have to tell people to wait to use the toilet, until staff are available."
●The manager was actively recruiting more staff. This included nurses and care staff. In the meantime, shifts were being covered by agency staff as required. The service did not use a dependency tool which would help them to gauge the number of staff required.
●People shared concerns with us that the service used a lot of agency staff. This was confirmed by the rotas we reviewed. The manager advised they were trying to use the same agency staff so there was some continuity.
●On the day of the inspection we observed there were enough care staff on duty to respond to people's needs, despite staff being constantly busy. However, we told the manager about the reservations some people had raised about the number of care staff on duty. Following the inspection, the manager advised us they had increased the staffing levels with the use of agency staff until the newly appointed staff had started.
● Although there was a recruitment process in place, we found that it was not consistently followed. For example, applicant's full employment history was incomplete and gaps in employment history had not been explored. This had been identified in our last inspection in 2017 and identified as an issue following a Local Authority visit in April 2019. Following the inspection, the manager advised they had amended their recruitment procedure to include looking at gaps in employment history.

Using medicines safely
●Senior care staff and qualified nurses took responsibility for administering medicines and we observed they did this with patience and kindness. One person said, "I get my tablets by the nurses every day."
● Systems to manage medicines were organised. Staff were following safe protocols for the receipt and disposal of medicines.
● Staff told us they had their competencies checked to ensure they were safe to administer medicines.

Preventing and controlling infection
● The service had a food hygiene rating score of five out of five, which equated to very good, when recently inspected by the food standards agency.
●Staff wore Personal Protective Equipment (PPE) when supporting people with personal care and handling soiled laundry.
● We observed floor lining in some communal bathrooms were raised and torn. As a result, they could not be cleaned to a hygienic standard. Following our inspection, we received information that the registered provider was addressing this concern.

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.

The last rating for this service was good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

● We found decisions had been made about people's care without the correct steps being followed under the Mental Capacity Act (MCA).
● Some people had been assessed for the use of monitors and bedrails to keep them safe. However, for some people, relatives had signed and given consent for the equipment to be used when the person had been assessed as having capacity to make these decisions themselves. When people lacked mental capacity, the registered manager had not ensured that decisions had been made for the use of the equipment in each person's best interests. In addition, we saw relatives had signed consent forms for people who had been assessed as lacking capacity without having the appropriate authority to do so.
●The majority of the staff we spoke with did not always know which people were subject to authorised DoLS and lacked knowledge and understanding about DoLS and what it meant for people who lived at the home. One staff member told us, "I'm not sure who is on one." Whilst we did not see this had immediately impacted on people's care and support, the registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS. In addition, care plans did not contain guidance for staff to follow to ensure least restrictive practices were followed.

The registered provider was not ensuring that people's rights were protected and this was a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Need for consent.

● We observed staff gaining consent from people before supporting them with their needs. For example,

asking people if they had finished their meals before removing plates.

Staff support: induction, training, skills and experience

● The majority of people told us that in their opinion staff had the skills and right experience to meet their needs. One person told us, "They look after me and I have no complaints." However, one person did not feel staff had the right skills to support them with their health condition. Whilst this did not have any impact on the person, we shared this with the registered manager who advised us they would look into this following our inspection.

●Staff told us that training was effective and gave them enough information to carry out their duties safely. However, the registered manager was not able to identify staff's current training needs and dates of refresher training in areas considered by the provider to be mandatory; this included specific health related training. A training matrix was not available or up to date to support the service to identify when training should be provided.

●The nursing staff we spoke with told us they had been supported to revalidate their registration. However, the records we reviewed did not address how nursing staff continue their personal and professional development. In addition, there was no discussions around the clinical oversight and accountability of their roles.

●Care staff told us, and records showed that newly recruited staff undertook induction training when they first started to work for the service. This included the Care Certificate, which is a nationally recognised set of standards to ensure staff have the right skills, knowledge and behaviours.

● Care staff we spoke with told us that they felt supported in their roles and that the management team were approachable.

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

●People's needs were assessed prior to admission to make sure their needs could be met by the service. Some of these assessments did not include information about people's life history, culture, religion, sexual orientation and other preferences which would enable the service to deliver more personalised care under the Equality Act.

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

●People were supported to have balanced diets and made choices about the kind of food they enjoyed. One person told us, "I suppose they do their best. I like it on Mondays and Tuesdays. If I don't like anything on the menu, they'll make something else for me."

● We observed staff asking people which vegetables they would prefer with their meal. We observed some people receiving assistance from staff to eat.

● People told us they were not involved in the planning of meals and records we sampled confirmed this.

●There were snacks and drinks available for people however, these were not accessible to all people to access independently.

●Support from speech and language therapists had been sought when people were at risk of choking. This had been done to establish if a person's food needed to be prepared in a particular way. Care staff were following the advice they had been given. This included some people having their food blended and drinks thickened so they were easier to swallow.

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

● People told us arrangements were promptly made for them to see their doctor if they became unwell. One person told us, "The doctor does come out if I'm unwell."

●We saw staff had ensured that people had consultations with other healthcare professionals including chiropodists, dentists and opticians.

●Whilst care staff were knowledgeable about catheter care, there were no individual catheter care plans in place for staff to follow. This would ensure staff were consistent with how to provide safe and effective catheter care to the people they supported.

●Staff knew what action to take in an event of a health emergency or if someone was unwell due to their health conditions. However, care plans did not always contain detail and guidance for staff to follow. For example, people living with diabetes. The manager advised us they would ensure care records were updated to ensure they contained detailed guidance for staff to follow.

●The service made available a prepared a hospital passport of information to share with external agencies such as the ambulance service and hospital staff should it be necessary.

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.

The last rating for this service was good. At this inspection this key question has now 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 equality and diversity

● People gave us mixed views around how caring the support was that they received from care staff. One person said, "They are extremely nice. I love the place and I love being here. I have nothing bad to say about any of them; they are wonderful and each one deserves a medal." However, another person told us, "Some are good, and some are not so good. Some are not very caring, but they are stretched and under pressure all the time. They do the best they can."

● We observed busy periods of the day where staff did not have the time to talk or interact with people. One person told us, "They are very good but don't have the time to sit down and talk to you." However, throughout the inspection we observed a number of positive interactions between people and the staff who supported them.

● Some staff we spoke with understood people's needs based on their protected equality characteristics. One staff member told us, "You just treat everyone equally regardless of their religion or culture. People have the right to choose and to decide what they want."

● Overall the service provided at Valley Court was not caring and this could be demonstrated by the concerns found in the other areas of this report.

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

● People told us they were not always included in making decisions about their care and they were not always listened to by staff. One person told us, "I've never seen my care plan or been asked about one." Two people told us they felt like a burden because they needed extra care and support.

● We did observe staff supporting people to make decisions. For example, people were asked if they would like to participate in activities.

●Care plans were evaluated on a monthly basis by nursing staff. However, they did not show how staff had involved people or their families in discussions around care needs.

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was not consistently respected and promoted. Although staff we spoke with were aware of how to promote people's dignity, this had not been consistently practiced.

●Some people's daily care notes were not written in a respectful manner. For example, one person was described as being in a bad mood and nasty to staff.

● Whilst staff told us they respected people's right to confidentiality this did not consistently happen in practice. We saw four people's care notes left unattended in a communal area. Confidential and personal information pertaining to people was available for anyone to access who lived at the home and or visited.

● Whilst we observed staff promoting people's independence during meal times; we did not observe many opportunities for some people to take part in everyday living skills, for example, helping to set a table for lunch, or making themselves a drink if they wanted.

●At other times, privacy was considered; for example, when providing care to people discreetly a relative told us that they were advised politely by staff that they were going to give their relative personal care or apply creams therefore, they would ask them to wait outside to maintain their dignity and privacy

●People had been supported to personalise their bedrooms with items of their own furniture, photographs and keepsakes.

● People were supported to maintain important relationships. One relative told us, "I visit two or three times a day, that's important to my mum."

Requires Improvement

Is the service responsive?

Our findings

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

The last rating for this service was good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People gave us mixed views as to whether they felt their needs were being met at the service. We received both positive and negative feedback. One person said, "All the staff know me, I'm not neglected." Another person told us they did not engage with other people who lived at the home and said, "I wish I had someone to talk to. When I go to the lounge, they are all asleep."

● Some people of a younger age told us they felt the service was not responsive to their age group. One person said, "They have things going on, but I have given up on them. I'm younger compared to the others." Another person said, "Activities are specifically for seniors and it's my choice not to go there."

● People's care plans were reviewed regularly, but these reviews were not meaningful. There was no evidence that people had been actively encouraged to be involved in discussing or reviewing their own care on a regular basis. One person told us, "I've not been involved in my care plan." This meant there was little evidence that people had any choice or control over their own support.

● People told us their pastoral care needs were met. A member of staff said, "We have different religious services here for people to access."

●There was little for people to find to enable them to engage in independent activity such as accessing objects to occupy and stimulate, this would enhance the quality of life for those people living with dementia. We observed a supply of sensory and tactile objects within the activity room, which a lot of people did not access due to being cared for from their beds. There were some pictorial signs on doors to denote bathrooms and toilets.

● People were not consistently encouraged to access and integrate with the local community with support from staff to reduce social isolation. People and staff told us there were no regular or planned trips out.

●However, during the inspection we observed two staff members dedicated to activities and people responded well and spoke highly of them. We observed leisure opportunities and protected times were in place to support people who lived in their rooms to help to prevent social isolation. In addition, we observed group activities in the form of afternoon tea taking place.

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.

● Information was not always presented in ways that were accessible. We did not see alternative means of communication. For example, some parts of people's care plans were not written in a user-friendly way

using an easy-read style with pictures and graphics. Similarly, menus and the provider's complaints policy were also not available in accessible formats. This meant people did not have easy access to information regarding the service they should expect to receive or guidance on what to do if they were dissatisfied. The registered manager advised us they would develop all information in line with the AIS.

End of life care and support

● People could not be confident their wishes during their final days and following death would be understood and followed by staff. The service had not explored people's preferences, choices, cultural or spiritual needs in relation to their end of life care.

●Some people had been identified as entering their final days of life. The end of life care plans were very task orientated with no personalised detail added to give staff guidance on what this person or their relatives would want their end of life care to be like.

●There were arrangements for the service to hold 'anticipatory medicines'. This is so that medicines are available for nurses to quickly dispense in line with a doctor's instructions if a person needs pain relief.

Improving care quality in response to complaints or concerns

● People told us they knew how to complain if they wanted to. Most people told us they would speak with the manager or a member of staff if needed. One person said, "You can talk to staff at any time about anything." One relative told us, "I'm confident to raise a concern and I'm confident it would be listened to."

●We saw people's complaints had been investigated and the outcome reported back to people or their relative. Checks had been made to ensure they were satisfied with the outcome.

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.

The last rating for this service was good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not assure the delivery of high-quality and person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People's health and well-being was not sufficiently protected as the governance systems to monitor the service were not robust or effective.
- People were not protected from the risks associated with malnutrition. We found that food and fluid monitoring charts had not always been completed fully.
- People were not protected from the risks associated with skin damage. For example, one person had not received their prescribed topical cream protect their skin. Medication audits in place had not identified this shortfall.
- There were no risk management plans in place to guide staff how to use specialist equipment to help them to transfer safely.
- Care plan audits had not identified that guidance was not in place for staff to follow to support people to maintain their health and how to support people in a health emergency.
- Tools which could assist the provider to analyse the number of staff required to keep people safe were not in place. For example, a staffing tool which reviewed people's dependency or analysis of the amount of time people waited for their call bells to be answered.
- There were no systems in place to ensure recruitment processes were robust.
- There were no systems in place to show that learning from accidents and incidents had taken place or how the information gathered had been used to prevent or reduce the likelihood of a reoccurrence.
- There were no effective systems in place to check the competency of both nursing and care staff to ensure they were equipped with the skills needed and were applying their learning into practice.
- Governance and oversight systems had failed to ensure the registered provider was working consistently in line with the principles of the Mental Capacity Act (2005).
- The quality audit system for the environment was ineffective. Recommendations following a fire safety concern in March 2019 had not been adhered to.
- The registered persons had not established all the systems and processes that were necessary to operate, monitor and evaluate the operation of the service. Although quality checks had been completed of key aspects of the service they had failed to identify the shortfalls we have already listed in our inspection report.

There were insufficient and robust systems in place to monitor and improve the quality of the service. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People and their relatives told us they knew who the registered manager was and most felt they were approachable. One person told us, "[Name of manager] comes around to see me. She's quite approachable."

● People told us, and records corroborated that they were not involved with the planning and reviewing of their care plans.

●There were no quality assurance systems in place to consider adapting information to meet people's individual communication needs.

●People were not routinely involved in reviews of their care. This, coupled with the lack of feedback obtained from people, meant the provider could not be confident people were satisfied with the care they received.

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

● Whilst there were systems in place to involve people in service improvement, people's views about the quality of care they received had not been sought effectively or acted upon. People had not been empowered to make suggestions that would improve their quality of life and had not been given the opportunity to shape and improve the service.

● Staff told us they had opportunities to attend meetings with the manager to discuss the service and raise any issues. A staff member said, "The manager is fair and listens to us, always available."

Continuous learning and improving care; Working in partnership with others

● The registered manager was new to post and there was no evidence to demonstrate how they had been supported by the registered provider. In addition, there was no evidence to demonstrate the provider had carried out quality assurance monitoring to inform them of positive aspects of the home and identify areas for development.

● The service worked closely with the local authority and health professionals as they carried out regular visits to the service.

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 provider had a duty of candour policy in place and they were aware of their responsibilities to be open and transparent when things went wrong.

●The manager understood their duty of candour and the responsibility to notify CQC of all significant events affecting people at the service.

●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 provider had conspicuously displayed their rating in the home. The provider did not have a website in use at the time of our inspection.

● Following our visits, we requested and received information which assured us action was being taken to mitigate the risks we had identified for people.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought from people using the service. Regulation 11 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm due to poor risk management processes within the service. Regulation 12 (2) (a) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. Regulation 17 (1) (2)(a)(b)