Heathcotes Care Limited

Heathcotes (Magna)

Inspection report

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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

About the service
Heathcotes (Magna) is a residential care home providing personal care to four people at the time of the inspection. The service specialised in supporting people who have learning disabilities, autism, Asperger's syndrome and challenging behaviour.

The care home was registered to support up to six people in one adapted building.
The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service should receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
There were not always enough care staff to safely meet people's needs. This also limited the opportunities for people to go out and engage in activities in the local community.

People's medication was not managed effectively and the information available to care staff in care plans was not always accurate.

Care staff had not all received safeguarding children training. This meant some staff did not know how to keep young people safe from abuse or how to report incidents to the relevant authorities.

Notifiable incidents, involving people, were not always reported to CQC. This meant the relevant authorities were not always able to ensure people were receiving appropriate care and support.

Lessons were not always learned when things went wrong. Reviews took place after incidents but were not effective and did not always lead to improvements in the care people received.

People were supported by some care staff who had not received the necessary training. This was especially the case at night time. This meant people were not always supported appropriately.

People had been restrained by some care staff who were not up to date with their training and who carried out unauthorised restraint techniques.

People had personalised their bedrooms. However, the communal areas needed refurbishment following damage caused by a person. This meant the house did not feel 'homely' or relaxing.

People were able to make use of the garden area, and enclosed carpark, for outdoor activities.

People had enough to eat and were offered a range of different foods, as well as being supported to go out into the community for meals occasionally.

Care staff treated people with kindness, but people's dignity was not always maintained by the way care staff supported them to dress.

Some people had found it difficult to cope with the frequent changes in managers and care staff at the care home. That negatively affected the support people received.

Some people were supported to maintain contact with their families, but other people were not.

The registered manager had a quality assurance system in place to monitor the safety and quality of the service. However, this was not being fully, or effectively, used to assess, monitor and improve the quality and safety of the service provided to people.

People were supported to access community healthcare support, and had health action plans in place.

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

Rating at last inspection
The last rating for this service was good (published 5 July 2017).

Why we inspected
The inspection was prompted in part due to concerns received about the improper use of restraint on people who can present behaviours that are challenging. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the five key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.
Since the inspection took place the provider notified CQC about a change of registered manager.

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?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always 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.

Heathcotes (Magna)

Detailed findings

Background to this 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 care home was inspected by one inspector.

Service and service type
Heathcotes (Magna) is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 two managers registered with the Care Quality Commission at the time of the inspection. 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
The inspection visit on 8 July 2019 was unannounced. We returned, announced, on 9 July 2019 to complete the inspection.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work at the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We observed care staff interactions with people. We spoke with seven members of staff including the registered manager, team leaders, and care staff.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two 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. We looked at training data and quality assurance records. We spoke with three relatives about their experience of the care provided. We obtained feedback from two professionals who had regular contact with the service. We obtained fire safety advice from Leicestershire Fire and Rescue Service.

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 this key question was rated as good. At this inspection this key question has now 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.

Staffing and recruitment

- There were not always enough care staff to meet people's assessed needs. For example, the care home was understaffed on five afternoons in the week prior to the inspection. The number of care staff on duty was less than the number the provider had identified were necessary to meet people's needs.
- We sampled rota records, and other documents, covering two randomly selected weeks in a three-month period. On one of those weeks, there were insufficient care staff on duty each day. The registered manager also told us the care home had been regularly short staffed since April 2019 and the required care staff levels had not always been maintained. The registered manager told us they had recently started using agency care staff as a way of increasing the numbers of care staff available, but that there were still days when insufficient care staff were available.
- A care staff told us, "It's because of high sickness levels, and staff are worn out because of the recent incidents. We struggle more in the afternoons because there are often less staff on shift." We saw rota records which showed that care staff sickness levels were sometimes an issue at the care home.
- In the week prior to the inspection, three night shifts had too few suitably trained care staff on duty. A relative told us, "The night staff just don't understand [person's] needs. There are more incidents, or at least more serious incidents, happening at night time." We saw incident reports which corroborated what the relative had told us. Having insufficient numbers of suitably trained care staff on duty meant people could not always be supported safely when they became anxious or demonstrated behaviour that challenged.

The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced care staff deployed to meet people's assessed care and support needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had an effective recruitment policy and procedures in place, and the necessary staff pre-employment checks had been carried out. When agency care staff were used the provider ensured appropriate pre-employment checks had been carried out by the agency. This helped to ensure care staff were safe to work with vulnerable people.

Using medicines safely

- The provider did not follow safe protocols for the receipt, storage and administration of medicines. For example, on one occasion, care staff administered medication, which was not prescribed, to a person receiving respite support at the care home. This resulted in the person going into hospital.
- The controlled drugs record book was not being used and details of controlled drug checks were recorded

on an inappropriate form. Care homes should keep a record of any controlled drugs in their controlled drugs book. This was brought to the attention of the registered manager who immediately arranged for the controlled drug record book to be put back into use.
● People's medication profiles were not accurate. For example, two people received medication which was prescribed for them but not listed on their medication profile. Care staff used medication profiles as a guide to understand why people took medication and whether there are side effects to be aware of. This was brought to the registered manager's attention who immediately arranged for the medication profiles to be corrected.
● The registered manager's monthly audit of 'as and when required' (PRN) medication was not accurate. For example, the June 2019 audit report stated a person received one dose of PRN medication whereas the medication administration record stated the person had received three doses. The effective review of PRN medication is required to prevent potential overuse.

The provider failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Team leaders, and some care staff, were trained in how to administer prescribed medications, when people required them. This was underpinned by the provider's medication policy to which care staff had access.

Systems and processes to safeguard people from the risk of abuse
● Not all care staff had received safeguarding children training. The provider supported a young adult at the care home and care staff required appropriate training so they understood how to protect young adults and children from the risk of harm and abuse.
● All care staff had received safeguarding adults training, were aware of the safeguarding procedure, and how to use it. There were safeguarding adults' policies in place, which care staff had access to.
● The registered manager understood their responsibilities for keeping people safe, including the requirement to report safeguarding issues to the relevant authorities. However, we found two reportable incidents had not been notified to CQC. These related to an incident when a person was hospitalised following the administration of a non-prescribed medication and an incident when Police attended the care home because of staff being assaulted by a person.

Assessing risk, safety monitoring and management
● The legionella risk assessment stated shower heads needed to be descaled regularly to reduce the risk of a legionella infection. Descaling was not being done. This was brought to the registered manager's attention who told us they would ensure this was done.
● The provider had a fire risk assessment in place and effective systems to carry out regular fire safety checks. However, most fire extinguishers in the care home were stored in a locked cupboard to prevent people from interfering with them. The fire risk assessment had not been updated to reflect that change. This was brought to the registered manager's attention and advice obtained from Leicestershire Fire and Rescue Service. After the inspection, the registered manager told us the fire risk assessment had been updated in line with that advice.
● Care staff had received fire safety training and personal emergency evacuation plans were in place, so people could be supported to exit the care home in an emergency.
● People's individual risks had been assessed and reviewed regularly by the registered manager. Changes in people's risk assessments were discussed at staff handovers. A care staff told us, "When we get some quiet times on shift we read them then." This helped to ensure people were protected from avoidable risks.

● Routine health and safety checks had been carried out, which helped to ensure the care home environment was kept safe.

Preventing and controlling infection

● People's rooms, bathrooms and communal areas were clean, A care staff told us, "The team leader is our infection control lead. Everywhere is sanitised regularly and we have a daily rota for cleaning." This reduced the risk of infections spreading.

● Care staff told us each person's laundry was done separately and there were suitable arrangements in place for keeping soiled clothing separate. This reduced the risk of cross contamination.

● All care staff had received training in infection control procedures as part of their induction.

● The provider had an infection control policy and personal protective equipment, such as disposable gloves and aprons, were available and used to prevent the spread of infections.

Learning lessons when things go wrong

● The registered manager regularly reviewed incidents reports. However, the reviews were not detailed enough to identify measures to prevent reoccurrence. For example, after a series of incidents in the kitchen the review document simply stated the "kitchen is a known trigger". This meant incident reviews were not effective.

● Lessons were not always learnt from incidents. For example, following the medication error which led to the hospitalisation of a person receiving respite care, the provider had not taken the necessary improvement action to ensure the medication administration records and medication profiles were accurate.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as 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.

Staff support: induction, training, skills and experience

- The provider had a staff training plan to identify when care staff required training. However, not all care staff received the training they needed to meet people's support needs. For example, not all staff had received autism awareness training. That meant some staff had a limited understanding of the needs of the people at the care home who have autism.
- Waking night staff had not all received enhanced challenging behaviour training even though incidents had occurred during the night. This meant the night care team were often unable to meet people's needs when people became anxious or presented behaviour that challenged.
- Care staff restrained a person on the floor during an incident of challenging behaviour. One care staff had used an inappropriate technique which was investigated, and dealt with, by the provider. However, enhanced restraint training for two of the staff involved had expired and a third staff member had never received training in enhanced restraint techniques. This lack training meant those care staff carried out an unauthorised restraint technique on the person.
- Care staff told us the provider's challenging behaviour training included techniques which could be used to de-escalate situations when people became aggressive. However, care staff had not always used de-escalation techniques adequately before implementing restraint.

The provider failed to prevent acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. This placed people at risk of harm. This was a breach of regulation 13 (4) (c) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- New staff completed structured induction training, which included working alongside more experienced care staff.
- Care staff told us they received regular handover sessions and supervision meetings. This provided staff with opportunities to share information about the people they support.

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

- The care home required repair to the internal decoration in communal areas because of damage caused by a person. The provider had made the building safe and it had been agreed the person would move out of the care home. The provider had decided not to replace some of the internal decoration and fittings until that person moved out. This meant the care home did not have a homely 'feel' in the communal areas.

● Most people had personalised their bedrooms to express their interests. However, the provider had not supported a person to continue with their model railway hobby when they changed bedrooms. This was brought to the registered manager's attention who told us they would have the necessary shelving re-installed.
● The garden area included a specially adapted swing, with a nearby music speaker. We observed a person using it to relax outdoors.
● The care home had an enclosed car park area. We observed a person, supported by a care staff, enjoy using the area to safely ride their scooter.
● People's bedrooms had ensuite toilet and shower facilities. However, the communal bathroom was not in full use due to damage caused by a person. The registered manager told us repairs had been requested from the provider's maintenance team.
● The external door bell, located near the gate some distance from the care home, was broken. That made it difficult for visitors to gain entrance to the care home. This was brought to the registered manager's attention who told us they would arrange for its repair.

Supporting people to eat and drink enough to maintain a balanced diet
● One person's care plan incorrectly stated they needed lose weight. This was brought to the attention of the registered manager who immediately corrected the person's care plan.
● People were supported to eat and drink safely and maintain a balanced diet. For example, where the need for support had been identified, care staff cut food into easier to swallow pieces.
● People were offered a variety of food and drink they enjoyed, and alternatives were readily available if people preferred something else. People were also occasionally supported to go out for meals in the local community. That increased the variety of food and drink options available to them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The registered manager created care plans which were updated as people's needs changed. A care worker told us, "Every time they are updated we are given the care plan folder and we read them". This showed people's support needs were regularly assessed and care plans made available to care staff.
● Positive behavioural support plans were in place to guide care staff on how to support people experiencing distress or anxiety. The support plans identified when prescribed sedative medication, or physical restraints, should be used. However, not all care staff followed the guidance on how to de-escalate situations and avoid the need for restraints to be used.

Staff working with other agencies to provide consistent, effective, timely care
● Care staff had not always communicated with other agencies effectively. A social worker told us, "Better communication is key to improving service user's outcomes. Extremely slow to respond, and only managers have access to [the care home's] email which is very strange given they work with extremely vulnerable service users."
● Care staff did not always follow recommendations from other agencies. A health care professional told us, "The care provided was inconsistent and not always in line with the care plans given by myself. I feel they forgot the person at the heart of the matter and focused on solving the "problem" (ie the patient) when things got very difficult."

Supporting people to live healthier lives, access healthcare services and support
● The registered manager ensured people had annual health checks with their GP.
● People had health action plans in place which detailed their individual health support needs, as well as records of visits to specialist and community healthcare services.

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 care home was working within the principles of the MCA and DoLs and whether any restrictions on people's liberty had been authorised. We found it was.
● All care staff received training in relation to MCA and DoLs and worked within the principles of MCA. Appropriate referrals to the local authority DoLs team had been made and the registered manager had chased up referrals not processed by the local authority in a timely manner.
● People had given their consent to receive care from the provider and, where it had been assessed an individual did not have the capacity to give consent, there had been an appropriate best interest process carried out.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as 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

- Care staff support was not always consistent. A relative told us, "The day staff are really good and supportive towards [Person], but the night staff just didn't understand his needs. They couldn't manage his behaviour in the correct way and that led to lots of incidents happening."
- Care staff treated people with kindness. A relative told us, "The staff are always very good. They have some new young staff working there and [Person] really likes them." A health care professional told us, "I felt the direct staff working with the patient were kind and caring, but I felt the fact the patient was a person was missed by management."
- Care staff received training about the provider's values during their induction. This is supported by the provider's equality and diversity policy to which all care staff have access.

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always maintained. During the two day inspection we observed a person dressed in trousers that were too short and which looked undignified. Care staff told us they purchased clothes from charity shops because the person had limited money. However, a relative told us the person had money available to buy whatever he needed. This was brought to the registered manager's attention who told us they would address this with the care staff and contact the relative.
- Not everyone was supported to develop their independent living skills. A social worker told us, "Based on my experience, there is no evidence staff supported my young client to develop any independent living skills." During the two inspection days we did not see the person being supported to do structured activities. This meant the person was not supported to develop the skills they needed to live more independently in the future.
- Some people had learned new skills in the past. A relative told us, "Since he has been there he has done really well. He loves going on the bus with staff, he has no problems on the bus at all now. I can go out for a meal with him now, no problem at all. He uses a knife and fork properly, and he always looks clean and tidy."
- A care staff told us, "We always knock on doors before entering bedrooms, and ask permission before doing any personal care." This helped to protect people's privacy.
- We observed care staff interacting with people in a caring way.

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

- People were supported to indicate whether they consented to receive the support as detailed in their care plans. Where that was not possible appropriate best interest processes were in place.

Requires Improvement

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 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

● There was no effective means of ensuring care staff had read and understood people's care plans. Changes in support needs were discussed at staff handovers. However, there was contradictory information in one person's care plan which had not been identified by the care staff who had signed to say they had read it. This had the potential to affect people's safety.

● People had not always received personalised care which met their needs. Not all staff understood how to support a person who displayed behaviours which could become very challenging. This meant incidents escalated which adversely affected the person and the other people they lived with.

● A social worker told us, "The care home has had three managers within a short space of time which, in my view, has had a negative impact on [person's] welfare. I'm not happy with the overall service that my young person received from the placement." The frequent changes in management meant personalised support was not consistently planned and provided.

● Care workers did not always support people to make choices about how they spent their time. A care staff told us activities offered to people were often limited by a shortage of care staff on duty.

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.

● The registered manager understood the Accessible Information Standard. We saw some documents in care plans which were in an easy-read format. However, the notice boards in the communal areas had been removed, which limited the information readily available to people. The registered manager told us the noticeboards would be replaced as part of the redecoration work.

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

● Some people were supported to maintain contact with their relatives. A relative told us, "The staff bring him to see me each week. He goes to Church with me and we have a meal afterwards. He also goes to the social club and he enjoys it there with me." However, another relative told us, "I did ask that [Person] come up to visit like he always used to do, on his birthday. I spoke with a manager about it, but then they left. Then another manager left. So, it just didn't happen." Supporting people to maintain contact with their relatives is important and helps prevent social isolation.

● People were supported to go out into the community. This included trips to the local park, shopping and

meals out. However, these trips only occurred when there were sufficient care staff on duty to provide the necessary support.

Improving care quality in response to complaints or concerns

● Complaints and concerns were not always dealt with in a timely manner. A social worker told us, "I was not receiving incident reports; therefore, I made a complaint to the regional manager because the home manager didn't address my complaints. Even the regional manager didn't address my complaints on time."

● Relatives and staff told us they did not know who the registered manager of the care home was, because there had been several changes in management. The care home had two registered managers at the time of the inspection. However, one had taken up a post at another of the provider's care homes. The second registered manager was also the provider's regional manager which meant they were often required to be at other care homes. This meant there was confusion about who to contact with concerns and complaints.

● There was no complaints procedure on display in the communal areas of the care home because a person had damaged the notice boards. The registered manager showed us a copy of the 'easy read' complaints procedure, but that included a previous manager's contact details. The registered manager immediately corrected the 'easy read' complaints procedure.

End of life care and support

● People had end of life plans within their general care plans, although no one was receiving end of life support at the time of the inspection.

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 now deteriorated to requires improvement. 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.

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

- The registered manager did not effectively support the care staff to provide person centred support which achieved good outcomes for people. Staff roster management meant there were days when insufficient care staff were available to meet people's needs. This meant people were not always effectively supported when they presented concerning behaviours, and that also limited their opportunities to engage in activities in the community.
- Care staff told us their morale was usually very high. A care staff told us, "If it wasn't for the staff getting on so well, it wouldn't run. It's because we all care. Staff have kept the place going for the last few months."
- Care staff did not know who the registered manager of the service was. A previous registered manager left the care home and there had been different management cover arrangements put in place by the provider. Care staff did not know the regional manager was also the registered manager of the care home. Care staff told us they did not know what roles the interim managers had at the service. This meant the service did not have a positive direction or an empowering culture and was focussed mainly on coping with day to day challenges.
- The registered manager, and all the staff we spoke with and observed, told us they were committed to providing person centred, high quality care. However, this was not always provided when staff numbers were low and this commitment to quality had not been converted into co-ordinated improvement action.
- The rating from our previous inspection was displayed in the manager's office. The rating was not displayed in the communal area because a person had damaged the notice boards. The registered manager told us these would be replaced so visitors could view the inspection rating more easily. The rating was also displayed on the provider's website.

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

- The registered manager understood their responsibility for reporting deaths, incidents, injuries and other matters that affected people using the service. However, not all reportable events had been notified to the CQC. Notifying the CQC of these events is important so we are kept informed and can check that appropriate action had been taken.
- All care staff understood their roles within the care home.
- The management of staffing levels was not effective. The rota records at the care home were not accurate and did always identify which staff had been on duty. This meant the registered manager was not always

aware of the actual staffing levels at the care home.
● The provider had told us, in the provider information return, that the home ensures the appropriate mix of skills of the staff team by utilising a skill matching tool. That was not the case.
● The provider carried out quality audits of the service along similar lines to a CQC inspection. This had previously identified areas requiring improvement. However, not all improvements had been made and progress had been hampered by interim management arrangements. The registered manager was also the provider's regional manager, responsible for overseeing the managers of other care homes. Clear management guidance and direction was not always available to the care staff at this care home.
● The registered manager had a quality assurance system in place to monitor the safety and quality of the service and to review incidents. However, they were not being used to their full potential to improve the service provided to people.

The systems and processes in place to assess, monitor and improve the quality and safety of the services provided were not fully or consistently effective. This was a breach of regulation 17 Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Working in partnership with others

● The registered manager and care staff worked in partnership with other professionals and agencies, such as GPs, community health services. However, some health and social care professionals identified issues that had not been acted upon when raised with the interim managers. A health care professional told us, "I did raise a lack of communication as a concern as the home failed to communicate problems in a timely manner, which could have impacted on the outcome for the patient. Slow communication continued to be an issue for some time after this."
● Relatives told us communication with them could be improved. A relative told us, "When [Person] first moved in the contact with the manager was really good and I was kept informed about things. Then when she left that all seemed to stop." This meant families were not always supported to be involved in their relatives' care.

Continuous learning and improving care
● The registered manager understood the importance of learning lessons, by reviewing incidents. However, this was not always effective. For example, repeated incidents had occurred at night time and it had been recognised that not all the night staff had the necessary training. However, that training had still not been provided to all the night staff. This meant people were not appropriately supported.

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 registered manager understood their duty of candour responsibility to contact relatives after incidents involving family members occurred. The provider had told us, in the provider information return, that copies of all duty of candour letters sent to relatives, following incidents, were kept. However, none could be located at the care home during the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had told us, in the provider information return, that quality surveys were carried out twice a year. That was not the case. The registered manager told us quality surveys were sent to relatives and care staff once a year. There was evidence of action being taken because of feedback from relatives, but there was no evidence of any action taken from the staff survey.
● Resident's meetings had taken place, but the records of the meetings did not demonstrate how people

had been supported to meaningfully engage in the meetings, or what other steps had been taken to involve people in ways they could understand.

● People's equality and diversity characteristics were identified during the initial assessment process and recorded in each person's care plan. This was available to guide care staff and was supported by the provider's equality and diversity policy.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management of medicines. This placed people at risk of harm.

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 provider failed to prevent acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes in place to assess, monitor and improve the quality and safety of the services provided were not fully or consistently effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to

meet the assessed care needs of people.