CareEast Limited

Culrose Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service

Culrose Residential Home is a care home providing personal and nursing care to 26 older people at the time of inspection. The service can support up to 32 people.

People's experience of using this service and what we found
The service had failed to ensure that all moving and handling equipment was serviced in line with Lifting Operations and Lifting Equipment regulations 1998 (LOLER) regulations in order to ensure its safety and suitability.

Risks to people were not adequately planned for, managed or mitigated. Some care plans contained conflicting information, making it difficult to ascertain what care people required to keep them safe. The majority of the care plans we reviewed did not contain sufficient detail about the care people required to keep them safe.

Where people had distressed behaviours, there was not always sufficient information in care planning with regard to how people could be positively supported to avoid, reduce or deescalate the situation. Some people with complex mental health conditions which could impact their well being did not have care plans for these.

The service did not always identify signs of potential abuse such as unexplained bruising and investigate these to ensure people were safe.

The staffing level or the deployment of staff was not always sufficient to enable staff to respond to people's requests for support in a timely manner or for staff to respond to alert equipment such as pressure mats to reduce the risk of falls.

There was a high number of falls in the service. Whilst the manager had identified this, they had not identified the shortfalls we found in staff responding to call bells and alerts in a timely manner. This created a risk of people having falls and could also have contributed to the number of falls.

The service was not consistently clean throughout. Some items could not be cleaned effectively as the surface was broken or damaged. This increased the risk of the transmission of infection.
The service was not decorated and adapted in line with dementia friendly guidance. The environment was poorly maintained in the older parts of the building and this did not uphold the dignity and respect of people using the service.

Medicines were managed, monitored and administered safely. Recruitment procedures were safe.
The service was found to be in breach of eight regulations under the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. The quality assurance system did not appropriately identify the issues we found at inspection. Therefore, this was ineffective. The service had deteriorated in compliance with the regulations since the previous inspection.

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 'requires improvement' (published 19 September 2019).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the safety of equipment. This inspection examined those risks.

You can see what action we have asked the provider to take at the end of this full report.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Culrose Residential 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 (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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector. An Expert by Experience made telephone calls to people and their relatives to ask about their experience of the service.
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
Culrose Residential Home 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.

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 and professionals who work with the service. 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 used all of this information to plan our inspection.

During the inspection
We spoke with 5 relatives of people who used the service and 2 people who used the service. We spoke with 11 staff members including the registered manager and care staff. We reviewed 13 care records and 2 recruitment files. Multiple records relating to the quality, safety and monitoring of the service were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● At our inspection on 19 September 2019 we found the service in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people were not always appropriately managed and mitigated. At this inspection we found that the service was still in breach of Regulation 12, this was because risks to people were not always planned for, monitored and mitigated effectively and equipment had not always been serviced and maintained in line with LOLER regulations.

● Despite us identifying at our previous inspection that care plans for open wounds were out of date and not always updated when wounds healed, this situation had not changed at this inspection. For example, care planning in place for people with current pressure ulcers did not make it clear they had wounds which required care. Also, for people at high risk of pressure ulcers, care plans did not always make it clear how this risk was reduced. National Institute for Health and Care Excellence (NICE) guidance states that the majority of pressure ulcers are preventable. We found however, that 7 people had 8 different wounds between January and June 2023. Where people required repositioning to reduce the risk of pressure ulcers, we found that this was not always carried out in line with the person's care plan, and this omission had not been identified. We found in one person's care records, despite a strict plan for repositioning, that in an 11-day period there were 30 occasions when they were not repositioned in line with this plan.

● One person had been admitted to hospital with pressure ulcers and the hospital raised a safeguarding concern regarding these. We reviewed their care records prior to their admission and found they did not contain sufficient information on how to manage their risk of pressure ulcers. Their care plan did not reference any current pressure ulcers and stated they had intact skin. We also found that staff had incorrectly scored their pressure ulcer risk and subsequent risk assessment lower than it should have been. Despite this person requiring a repositioning regimen to reduce the risk of pressure ulcer development we found that prior to their admission to hospital there were 74 occasions where they were not repositioned in line with the regimen between 11 March and 12 April 2023. This meant we were not assured people received appropriate care to protect them from the risk of skin breakdown.

● 9 care plans we reviewed contained conflicting information about the care the person required. For example, one person's care plan reflected the need for a diet of normal consistency in the main body of the care plan and then a soft diet in the review sheet. This put them at risk of receiving food which was inappropriate for them. For those we reviewed, there were no care plans in place for people at risk of choking and care records did not make clear why some people were on modified diets and whether this was because of a swallowing difficulty. One person's care plan stated they had no swallowing concerns in the main body of their care plan but then referred to recent difficulty swallowing tablets in the review sheet. There was no information about how staff should reduce the risk of them choking.

● One person had been admitted to the service on 26 June 2023 but over a month later still had no care plans or risk assessments. This meant we were not assured that the service could have identified risks to this

person and taken action to protect them from harm.

This represented a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found that the service had not ensured that all their lifting equipment was serviced in line with LOLER regulations and in good working order. One hoist had missed two consecutive LOLER tests and had not been serviced for a year and five months. LOLER regulations state that to ensure safety and suitability of equipment and reduce the risk of failures all lifting equipment should be serviced by a competent person not more than every six months. In addition to the lack of servicing, there was a part broken off the hoist and this had not been identified by any of the staff. This placed people at serious risk of harm.

This represented a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Prior to this inspection we had received a number of whistleblowing concerns regarding insufficient staffing levels.
● People's direct or indirect requests or need for support were not always responded to by staff in a timely manner. There was a high number of falls occurring at the service and the measures in place to reduce falls for many people was to have a pressure mat in place. This was so staff could go and support them if they were moving around their bedroom unassisted. However, records we viewed of response times to call bells and alerts from pressure mats showed that on many occasions, staff were not responding to these in a timely manner. One person's sensor mat alerted on 9 July 2023 but staff took over 16 minutes to attend. When they arrived, they found the person on the floor with a head wound.
● We observed that staff were very busy during our inspection and were engaged in tasks. There were a number of communal areas that people could be present in, and we saw that staff were not always available in these areas to support people if required.
● The registered manager told us that they used a dependency tool to calculate the number of staff required and that this indicated that at present they were overstaffed. However, they had not independently identified poor staff response times to call or alert bells and taken action to investigate whether this was due to staff deployment or staff numbers.

This represented a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although, the two people we spoke with who were still independent and required less support than some people using the service said they felt there were enough staff available. They also did not require staff to anticipate their needs because they had the capacity to express themselves.
● Staff were recruited safely, and recruitment procedures were robust. Appropriate checks were carried out on the background of staff to make sure they were suitable to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
● Staff missed opportunities to identify potential abuse. Whilst staff were recording bruises they found on people, they were not filling in an incident form. This meant that unexplained bruising was not investigated to ensure that it was not caused by potential abuse or improper handling. Staff did not demonstrate an understanding of why unexplained bruising could indicate abuse.

● The registered manager had not identified that staff were not completing incident forms for unexplained bruising and therefore these instances had not been investigated.
● There was a safeguarding policy and procedure in place. However, we were not assured staff had adequate knowledge of safeguarding procedures because training records showed that ten staff required training in safeguarding.

This represented a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The service was not consistently clean. We found chairs that were soiled, in a poor state of repair and required thorough cleaning. Floors were not clean in all areas, nor were tables and other surfaces. There appeared to be a lack of attention to detail from cleaning, with spills of fluids down walls or dirt around fixtures and fittings not having been identified and acted upon.
● Some items could not be adequately cleaned because the surface of the item was broken or damaged. For example, damage to the coating on a handrail and damage to the surface of a wipe clean chair. This meant there was a risk that the spread of infections and cross contamination was not being appropriately managed.

● We were not assured that the provider was preventing visitors from catching and spreading infections.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

This represented a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● We were not assured that the service learned lessons when things went wrong. Whilst the service had identified a high number of falls, they had failed to identify all possible root causes of these, and this meant the high numbers continued.
● The service was told that they needed to make improvements with regard to the recording of open wounds at the last inspection in September 2019, and this placed them in breach of Regulation 12. However, at this inspection we found that these shortfalls continued.

Using medicines safely
● Medicines were stored, managed and administered safely.
● We compared the stocks of medicines against the record of administration. In all cases the number of

medicines remaining matched with the records, indicating that people's medicines had been administered in line with the instructions of the prescriber.

● Medicines audits were carried out regularly and we saw that action was taken where errors were identified.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the last inspection the service was found to be in breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was limited information to support that the principles of the MCA had been implemented. At this inspection, we found that these shortfalls remained and therefore the service is still in breach of Regulation 11.

● We found that the service was not always meeting the principles of the MCA. Whilst the majority of people had assessments of their capacity, some of these were generic, not person centred and were not decision specific. There was conflicting information within care records about whether people had capacity to make decisions. One person's care plan stated they had 'full capacity' but then in another part of their care records we saw an Deprivation of Liberty Safeguards (DoLS) application had been made for them. It would not be appropriate to apply to deprive someone of their liberty if they had capacity in all areas of decision making.
● One person living with dementia had been admitted on 26 June 2023 and had no mental capacity assessments, nor was there any evidence that a DoLS application had been made. This was despite the person being deprived of their liberty daily. The person was displaying distressed behaviours which staff were finding difficult to manage. Despite this, there was no care planning in place to instruct staff on how to support the person to reduce their distress. There was no record of any possible triggers for their distress

and any measures that staff could take to de-escalate the situation when they became distressed. Despite having advanced dementia, the service had not obtained a life history from the person's family and given thought to whether past events could be influencing their current behaviour.
● The registered manager didn't have a full understanding of what staff in a residential service should be able to manage. This meant staff did not have effective support. This meant staff were ill equipped to support people who displayed distress behaviours. The registered manager told us they had asked for support from external health professionals regarding this person's behaviour but had been turned down as it fell within the threshold of support the service should be expected to provide.
● This person had been prescribed a sedative medicine for use only when required. However, records showed that this person had received this medicine on most days since their admission, despite having not presented with behaviours that were a danger to themselves or others.
● Some care plans contained wording that did not promote people's dignity and respect or demonstrate an understanding of dementia. For example, people were described as 'wandering without purpose'.

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

Supporting people to eat and drink enough to maintain a balanced diet
● Some people using the service had been actively losing weight. There was no care planning in place to instruct staff on how they should be supported to reduce the risk of further weight loss or increase their weight if required. Eight people whose records we reviewed had lost a significant amount of weight over the past 6 months. Whilst some of these people still had a BMI in the 'healthy' range, there was a serious risk that continued weight loss at the same rate would result in them soon becoming underweight. The service had not identified this risk and acted upon it by ensuring there was an appropriate plan in place to mitigate this risk. Despite some people being referred to the dietician as a result of weight loss, we found that advice given by dieticians within letters sent to the home had not been transferred into care planning. It was therefore unclear how staff could implement these plans consistently. One person who had been admitted on 26 June 2023 had lost 6.3kg since admission but had no care plans, nor a malnutrition risk assessment. Therefore, it was unclear how the service was supporting them to reduce the risk of further weight loss. Another person was severely underweight with a BMI of 11.09 and had lost 9.6kg since January 2023. Despite this, their care plan did not reflect weight loss or robust plans in place to reduce the risk of malnutrition.
● Food charts we looked at did not evidence that people were being offered extra snacks in between meals consistently to boost their intake. Where people refused meals, there was no record of staff offering the meal or an alternative at a different time to see if they were more willing to eat. In the records for one person this meant that on occasions they had not had anything to eat between lunch time on one day and breakfast the next. This did not reassure us that staff were taking all opportunities to support people to eat enough to maintain good nutrition.
● Whilst the service did carry out audits of weight charts, they had failed to identify that those at risk of malnutrition did not have appropriate plans in place to mitigate those risks.

This represented a breach of Regulation 14 (Meeting Nutritional and Hydration Needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People did however, tell us the food was of good quality and they had adequate choice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of people's needs were not always carried out accurately. We found several pressure ulcer risk assessments and nutrition assessments had been filled out incorrectly, with either options being

incorrectly selected or left blank. This meant that the risk levels for some people were calculated as lower than they it should have been, leading to an inaccurate assessment.
● Care plans were not written in line with best practice guidance. They were too brief and did not contain sufficient information for staff to provide people with safe and effective care.
● One person had been living at the service for over a month but still had no assessment of their needs, care plans or risk assessments. That meant the service failed to ensure they had sufficient information about their needs to care for them.

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

Staff support: induction, training, skills and experience
● Some staff were not up to date with essential training required for their role. Training records we were provided with showed that 23 of 31 staff were out of date for their moving and handling training. Six staff had out of date pressure ulcer training, 9 had out of date dementia awareness training and 8 required an update to their basic life support training. Eight of these required an update to their first aid training and 4 were overdue for their fire safety training. In addition, 12 needed to complete training in the MCA and the nominated individual confirmed 5 staff needed to complete safeguarding training.
● An audit carried out on behalf of the provider on 10 July 2023 identified that there were some gaps in training but action regarding this had not been expedited given the importance of some of the subjects outstanding.

This represented a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff did however tell us they felt well trained and were supported by the registered manager. They said they felt able to raise concerns, request support and make suggestions freely. People and their relatives told us they had confidence in the practice of staff and felt they were well trained for the role.

Adapting service, design, decoration to meet people's needs
● The service was not designed and decorated in a way which met dementia friendly guidelines. For example, most of the service was painted white. This would make it difficult for people living with dementia to differentiate between corridors and different parts of the home, which could mean they were unable to navigate it independently.
● The environment of the service was not stimulating for people living with dementia and did not provide sources of interest and engagement for people who chose to walk with purpose around the building. For example, the majority of the building was painted white and that could make it difficult for people living with dementia to differentiate from different areas of the service and navigate more independently.
● Parts of the service were in a poor state of decoration and repair which did not promote the dignity and respect of those living there.

This represented a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support
● Whilst the service requested support from external healthcare professionals, there was often little, or no record of the advice given in care planning. This meant the advice could not be consistently implemented.

● Where people had current pressure ulcers and were receiving care and support from the community nursing team, there was no record of this or the care they were receiving in their care records.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care

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

- At our last inspection on 19 September 2019 we found that the service was in breach of Regulation 11 (Need for Consent, Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks were not always appropriately mitigated, the principles of the Mental Capacity Act were not implemented consistently, and the management of the service had not always identified and acted upon areas for improvement.
- At this inspection we found that the service had failed to make improvements and there were repeat breaches of Regulations 11, 12 and 17. In addition, the quality of the service had deteriorated further, and the service was now also in breach of Regulations 9 (Person Centred Care), Regulation 13 (Safeguarding service users from abuse or improper treatment), Regulation 14 (Meeting Nutritional and Hydration needs), Regulation 15 (Premises and equipment) and Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The registered manager and other staff had completed audits but these had been ineffective in identifying issues and ensuring timely action was taken to make improvements. For example, audits had been carried out of care records but failed to identify the widespread and significant shortfalls we identified.
- Where shortfalls had been identified, such as a high number of falls, the registered manager had failed to identify all the possible root causes of this. For example, they failed to review call bell and sensor mat alert response times and identify poor staff response times that could have contributed to the number of falls. This meant that people were not protected from further harm.
- The service had not been proactive in identifying shortfalls independently. For example, poor cleaning in the kitchen led to a food hygiene score of 2 being issued in November 2022. Whilst they have now acted and improved their score to a 5, they failed to identify these cleaning issues themselves. Poor cleaning in the kitchens placed people at risk of harm.
- Whilst the provider had employed a company to carry out audits of the overall quality of service provision on their behalf, this had not always been effective because it had not identified all the shortfalls we found. For example, a provider audit carried out on 10 July 2023 identified some shortfalls with the recording of fluids but did not identify issues with the quality of care planning. Some of the findings written in their report were inaccurate, for example it stated that all 'death and dying' care plans contain information about people's end of life wishes for all people using the service. However, one person didn't have any care plans

at all so this was not accurate.
● The registered manager told us that senior staff had been tasked with writing care plans, however there was little oversight of the quality of these, and the registered manager had not identified that these were not being written in line with best practice guidance. The training matrix provided did not evidence any formal training in writing care plans, so it is unclear how the service ensured staff had the appropriate skills and knowledge to draft people's care plans.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our concerns, most people's relatives told us they felt the service was well managed. They said they knew who the registered manager was and found them helpful and supportive.

Continuous learning and improving care
● The service had failed to learn from shortfalls found at the previous inspection and had not made improvements to comply with the 3 regulations breached at the last inspection. At this inspection the service had deteriorated in the 'safe', 'effective' and 'well-led' domains and these are now all rated inadequate. The service had deteriorated in other areas and is now breaching a further 6 regulations. This meant we are not assured that they are continuously learning and improving the care they provide.
● Whilst the service had identified some shortfalls, such as a need to redecorate parts of the service, they had not identified issues such as not meeting dementia friendly guidance. Progress in some areas was also slow, which compromised people's dignity and respect. For example, flooring was being replaced across the service, but this was ongoing for months and planned to remain ongoing for many more months. The flooring in some areas was heavily stained and was soiled and unpleasant. This had not been expedited to ensure people's dignity was protected.

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 service had positive working relationships with outside organisations such as external healthcare professionals.
● However, the provider and its registered manager did not always fully implement guidance received from external healthcare professionals because these were not transferred into care planning records.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives had the opportunity to attend regular meetings to give their views and participate in discussions about the future of the service. Minutes of these confirmed people's views on future activities were recorded and people were asked to share their views freely.
● Staff also had an opportunity to attend regular meetings where they were asked for their views and input, as well as the meeting being an opportunity to share best practice.
● Surveys were carried out of the views of relatives and people using the service. The results of the last survey showed that whilst these were mostly positive, these surveys did not cover all areas, such as staffing for instance. This was the same with the staff survey, so it was unclear how the service could collect data on whether people feel their need for support is met in a timely way and whether staff feel they have the time to support people when they need it.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9(1) The care and treatment of service users must – (a) be appropriate, (b) meet their needs and (c) reflect their preferences 9(3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include– 9(3)(a) carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent 11.— Care and treatment of service users must only be provided with the consent of the relevant person.

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 13.— Service users must be protected from abuse and improper treatment in accordance with this regulation. Systems and processes must be established

	and operated effectively to prevent abuse of service users. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment 15.— All premises and equipment used by the service provider must be— clean, secure, suitable for the purpose for which they are being used, properly used properly maintained, and appropriately located for the purpose for which they are being used. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.