Valley View Care Home Ltd

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Valley View Care Home Ltd is a residential care home providing personal and nursing care to up to a maximum of 33 people. The service provides support to people who have care needs, such as, diabetes, epilepsy, Parkinson's disease. Some people were living with dementia or had deteriorating mobility. At the time of our inspection there were 23 people using the service.

People's experience of using this service and what we found
Although improvements had been made to the identification and mitigation of individual risk, further improvement was ongoing to ensure people's safety.

There were improvements to how people were supported to make decisions and choices, however, people were still 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.

The provider had introduced new monitoring systems since the last inspection however; these were not always robust and required further improvement to make sure people received safe and good quality care. Monitoring systems introduced since the last inspection were not always robust to make sure people received safe and good quality care.

Staff understood their responsibilities in relation to keeping people safe, they felt confident in raising concerns. People could be assured their prescribed medicines were now managed better by staff. Staffing levels had improved, and safe staff recruitment practices continued to be in place. The levels of agency staff had reduced and the agency staff supporting people now were regular agency staff who were treated as part of the team. The management of fire safety had improved, staff had completed fire evacuation drills more regularly.

Staff continued to complete their training and the provider had a system to check this. Staff said they felt well supported. People received better care with their health needs and the advice of healthcare staff was now followed. People were happy with the food provided, and their meals, and told us they could choose other options if they wished.

Staff culture had improved, no staff reported concerns of bullying as they had at the previous 2 inspections. Staff said they felt listened to and were able to speak up if they needed to. Staff had only positive things to say about the provider and registered manager and were happy with the changes being made, such as the new electronic systems. The provider had engaged with people, relatives and staff, although improvements could be made around how they fed back the findings of surveys. The provider had submitted notifications to CQC as required since the last inspection.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 3 February 2023) and we found breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. The provider had previously been served with a notice to impose conditions on their registration which continued following the last inspection.

At this inspection we found the provider remained in breach of some regulations, however improvements had been made.

This service has been in Special Measures since 2 February 2023. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

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.

We have found evidence that the provider needs to make further improvements. Please see the Safe, Effective and Well-led sections of this full report.

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

Enforcement
We have identified breaches in relation to the assessment of risk, mental capacity, record keeping and governance at this inspection.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Valley View Care Home Ltd

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 Health and Social Care Act 2008.

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 2 inspectors 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 View Care Home Ltd is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Valley View Care Home Ltd is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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, including monthly reports submitted by the provider. We sought feedback from the local authority and professionals who work with the service. We requested feedback from the local 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 annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 3 relatives about their experience of the care provided. We observed staff interactions with people and their care and support in communal areas. We spoke with 11 members of staff including the nominated individual, the registered manager, nurses, senior care workers, care workers and kitchen staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 8 people's care records and multiple medication records. We looked at 2 files in relation to staff recruitment, and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management

At our last inspection, the provider had failed to ensure risks were robustly identified and managed to prevent harm and ensure people received safe care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this regulation.

● There had been an improvement to the assessment and management of people's individual risk factors, however, further improvements were still required. The provider had introduced an electronic care planning system, and this was working well, although still being developed further.
● Although a lot of information was recorded in people's care records, individual risks were not always highlighted to provide staff with appropriate guidance to take preventative measures. As the development of care plans and risk assessments were led by nurses, this meant the information care staff needed to know was often lost within the clinical information needed by nursing staff.
● One person had a diagnosis of type 2 diabetes. The risk of a hypoglycaemia (low blood sugar) and hyperglycaemia (high blood sugar) had been identified. The action to take in both of these events was comprehensively detailed to provide clinical guidance to nurses. However, the signs and symptoms of hypoglycaemia or hyperglycaemia, or how to prevent either complication, were not included. This meant people may be at risk of complications related to diabetes if staff were not sure of the signs to look out for.
● Some people became anxious and agitated. The guidance for staff to provide positive and consistent support at these times, to prevent escalation of anxieties was not always sufficient. One person became anxious and could become agitated, resulting in verbal and sometimes physical incidents towards staff. Staff were guided in the person's care plan to complete an ABC chart to document all incidents. ABC charts are used to monitor a person's distress and agitation in order to update care plans and risk assessments. Staff had not completed ABC charts after each incident – only 5 had been recorded since March 2023, however, their challenging behaviour care plan stated incidents were happening at least twice per week. The charts that had been completed were not recorded correctly or appropriately and this had not been picked up by the provider or registered manager.
● A monthly choking audit for the month of July 2023 showed a person had a choking incident. The person had not been identified as at risk of choking, however, they relied on staff to cut some of their food up, including meat. The person was recorded as telling staff it happened because a piece of meat was too big. After the incident their care plan and risk assessment was updated with the information, however, they only

recorded that meat must be cut up, not what size the food should be. This meant the person could be at risk of choking again.

The provider continued to fail to assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe. One person said, "I feel very safe, staff are there when I need them."
● Records of people's care and checks on their safety were better documented. These included when people could not use a call bell and staff needed to check on them, and when people had their bowels opened, to prevent health concerns relating to constipation. The risks associated with people who experienced epileptic seizures were now better recorded.
● Staff now had the opportunity to take part in more fire drills to practice their response in the case of an emergency evacuation.

Learning lessons when things go wrong
● Although accidents were recorded, such as falls, incidents were not always recorded to enable monitoring across the service, to learn lessons and prevent further occurrences.
● Some people became anxious at times which resulted in verbal or physical incidents with staff. These incidents were not always recorded on incident forms, so that analysis of incidents could be undertaken to learn lessons and support a positive and consistent approach by staff. This remains an area for improvement.
● Although the registered manager monitored accidents and incidents, they could not be assured records were accurate to learn lessons and enable continuous improvement.

Systems and processes to safeguard people from the risk of abuse

At our last inspection, the provider had failed to protect people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At this inspection, enough improvement had been made and the provider was no longer in breach of this regulation.

● The provider and registered manager had worked with the local authority safeguarding team following the last inspection to help to keep people safe. Safeguarding concerns had been raised appropriately with the local authority and CQC had been notified.
● Staff had a good understanding of how to keep people safe from abuse and what their own responsibilities were. People and their relatives told us they felt safe, and they would feel confident raising concerns if they had them. One person said, "Staff will come into my room to make sure I am ok. I am happier and safer now we are not using so many agency staff as feel better supported by people that know me well."
● Staff told us the provider and the management team were approachable so they felt able to raise concerns and were confident they would be acted upon.

Staffing and recruitment

At our last inspection, the provider had failed to ensure sufficient, skilled staff were deployed to keep people safe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulation 2014.

At this inspection, enough improvement had been made and the provider was no longer in breach of this regulation.

● Staffing had improved since the last inspection. A relative told us, "I feel that the care is better now there is more permanent staff and not so much agency use." The provider had recruited some new staff. Agency staff continued to be used to cover gaps in the staff rota, but this was now minimal. However, the agency staff used were regular, so knew people well.
● People told us they did not have to wait when they requested help. One person said, "They generally come quickly." We saw staff spending time with people, chatting, or helping them where they needed it. We did not find anyone calling for help or hear call bells ringing without being answered.
● Staff told us they thought there were enough staff to meet people's needs and that this had improved since the last inspection. However, they were also aware that the provider had not admitted any new people since the last inspection so the numbers of people they were providing care to had reduced. The provider and registered manager told us when they started to take new admissions, this would be planned slowly, ensuring sufficient staff were on duty so the quality of people's care did not decline again.
● The provider was continuing to follow safe recruitment practices. Gaps in employment had been explored and references had been received before new staff were employed. New staff's right to work in the UK had been checked.
● Disclosure and Barring Service (DBS) checks were carried out. DBS provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

At our last inspection, the provider failed to take appropriate actions to ensure medicines were managed in a safe way. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had been made and the provider was no longer in breach of this regulation.

● People were now receiving their prescribed medicines safely. The provider had changed from a paper based to an electronic medicines management system. This had worked well and had improved the management of medicines.
● People's medicines were now ordered, stored and administered safely. Medicines administration records were accessed electronically by nurses and medicines trained care staff. Safety measures were in place within the electronic system so the registered manager or whoever was deputising in their absence were alerted if there was a concern such as medicines not given.
● We made random counts of people's medicines and they all tallied with the medicine records. This meant we were assured people had received their medicines as prescribed. Where people were prescribed medicines to be taken as and when necessary, protocols were in place as guidance for staff to make sure they were given safely and for the reason they were prescribed.
● Temperatures of the medicines room and fridges were checked daily to make sure they were kept at safe temperatures to ensure the efficacy of the medicines stored.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
People were able to have visitors when they wished. People and their relatives confirmed this and there were visitors during the inspection.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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

At our last inspection, the provider failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had not been made and the provider continued to be in breach of this regulation.

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.

- We found the service was still not working within the principles of the MCA. Care staff were able to describe the basic elements of people's rights. However, people's rights were not always upheld and maintained in line with the MCA.
- One person had 4 mental capacity assessments in place, and it was deemed they did not have capacity to consent to these decisions. A best interest decision making process had not been carried out to enable best practice when making decisions for a person who lacks capacity. The record regarding best interest decision making stated N/A (not applicable). People's individual right to have their best interests taken into account when considering consent to specific decisions may not be upheld.
- The provider had installed CCTV cameras in all communal areas. Although notices were displayed to inform people and visitors, there had been no formal process to gain people's consent. Mental capacity

assessments and a best interest decision making process had not been undertaken for those people who may lack capacity to consent.
● Conditions attached to DoLS authorisations were not always clearly set out in people's care plans. Although the manager was aware of the conditions, care plans did not always set out a clear plan to ensure they were, and continued to be, met. One person's conditions included they were to have mental capacity assessments for personal care, bed rails use, medicines administration and continence care. However, mental capacity assessments had not been completed for 2 of these specific decisions.

The provider continued to fail to put into practice the requirements of the MCA. This is a continued breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

At our last inspection, the provider had failed to provide care and treatment to meet people's assessed needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection, enough improvement had been made and the provider was no longer in breach of this regulation.

● At the last inspection, people were not always referred to the GP or healthcare professionals in a timely manner. We found this had improved at this inspection and people had received the advice and healthcare they needed.
● When people's needs or health were giving cause for concern, staff alerted the nurse on duty, and if the nurse felt further advice was needed, they referred people to the appropriate healthcare agencies without delay.
● People's clinical needs were met by nursing staff. Some people had acquired pressure sores either when their health had deteriorated, or during a hospital stay. Nursing staff provided care for people's wounds but also referred to community specialist tissue viability nurses when needed to seek specialist advice. Some people were unable to swallow safely and their nutrition, hydration and medicines were administered through a tube. Nursing staff had the clinical knowledge to make sure people were able to receive their treatment safely in the service.
● People had access to dentists, opticians and chiropodists as well as specialist services such as physiotherapy, dieticians and speech and language therapists.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● No new people had been admitted to the service since the last inspection, so we could not check that people's needs were still being assessed before moving in. However, as the provider had a new electronic care planning system, people's needs had been re assessed when staff were transferring their information onto the new system. A person told us, "The staff know me well and know how I like things to be done, they will discuss any changes with me."
● Nationally recognised scoring tools were used to support people's health and care, such as to assess and calculate people's risk of malnutrition, or the risk to their skin integrity. These tools had been used to develop people's care plans to make sure their support met their needs.
● Best practice for oral health care in care homes continued to be in use to make sure people's oral care needs were met by staff, or with the encouragement of staff.

Staff support: induction, training, skills and experience

● Staff had the training they needed to provide people's care. At the last inspection, not all staff had received catheter care training despite supporting people with a catheter and we said this was an area for improvement. At this inspection, all staff had received this training.
● At the last inspection, not all staff had been involved in a fire drill and we highlighted this as an area for improvement. At this inspection, all staff had the opportunity to practice the procedure for an emergency evacuation.
● The provider made sure staff kept their training up to date and had a system to keep a check on this. Staff were supported in their role through regular supervision meetings with their line manager.
● Systems and procedures were in place to support nursing staff to maintain their skills and Nursing and Midwifery Council (NMC) registration as part of the revalidation process. Nursing staff continued to be supported to achieve revalidation.

Adapting service, design, decoration to meet people's needs
● Most people needed staff to help them move around, sometimes with equipment such as hoists. The layout of the service supported this. There was limited storage space, so equipment was often stored in bathrooms or on landings at the top of stairwells which could potentially cause an obstruction if not positioned correctly. We spoke with the registered manager about this who said that they would speak with the provider to prioritise equipment and furniture that needed to be kept.
● Many people spent time in their rooms, or were cared for in bed. Bedrooms were personalised and included family photographs, personal ornaments, and pictures on their walls.
● People who were able to move around more independently knew where they were going, and were not looking lost or confused, aided by signs to help them to find areas such as the lounge and dining room.

Supporting people to eat and drink enough to maintain a balanced diet
● People continued to be happy with the food provided. One person said, "The food is really good, and we get offered drinks and snacks during the day, we also get offered fruit."
● At the last inspection, a system was not in place for the management team to routinely monitor the amount of fluids people had drank. This had improved with the introduction of the electronic record keeping system. The registered manager was now alerted if people were not receiving the care they were assessed as needing.
● People who had special dietary needs were supported to maintain these. Diets such as low sugar, high calorie, low fat, or where people needed to have their food soft or pureed. The kitchen staff were aware of people's dietary needs and were updated daily.
● People had been referred to the appropriate health care agencies when staff were concerned about people's weight or where they had difficulty swallowing.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed 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.

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

At our last inspection, the provider failed to have effective systems in place to assess, monitor and improve the quality and safety of the service and failed to ensure that records were accurate and complete. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had also failed to notify CQC of incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection, not enough improvement had been made and the provider was still in breach of Regulation 17.

● At previous inspections we have found the monitoring and auditing processes were not robust, resulting in issues not being picked up, so action not being taken to improve. Following an inspection in June 2021, we imposed conditions on the provider's registration which required them to provide effective monitoring of the quality of the service. The provider was required to submit a monthly report to CQC to update on progress. At our last inspection we found the systems in place to audit the quality of the service continued not to be robust or sufficient to alert the provider of concerns and issues within the service. At this inspection, although we found improvements had been made in this area, there were still some concerns around the provider's monitoring processes.
● The provider had stated in the monthly report to CQC in July 2023 that all care plans were audited once a month. We found this was not the case. The registered manager confirmed they did not carry out monthly care plan audits. The provider had also reported they had extra storage space in an external shed. However, we found that storage was still an issue inside the service at this inspection.
● Although care plans were now regularly reviewed by staff and they contained more information, we found that, as care plans had not been audited, areas that still needed to improve had not been picked up. The guidance staff needed to provide good and safe care was not always clear, some individual risks had not been identified and mitigated against, staff were not always completing records such as ABC charts, and the principles of the MCA were not always adhered to.
● The provider audits were mainly recorded on the new electronic system. This was a recent transition and some audits continued to be paper based. Time was needed to be able to assess if the system provided the robust approach that was needed to provide assurance of the provider's ability to recognise issues and sustain improvements.

The provider continued to fail to operate a robust quality assurance process to understand and have oversight of the quality of the service and ensure any shortfalls were addressed. This is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● At the last inspection, daily records had not been reviewed regularly to ensure people were safe. This had improved, daily records were checked every day and alerts were sent to the registered manager if care was missed or not recorded.
● At the last inspection, some staff had continued to report a culture of bullying, particularly towards new staff. At this inspection, we had no reports of these concerns from staff. Staff, including new staff we spoke with told us they had been welcomed and supported well.

At this inspection, enough improvement had been made and the provider was no longer in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● At the last 2 inspections, the provider had not always submitted statutory notifications including DoLS applications that had been authorised, in a timely manner. At this inspection we found, CQC had been notified of all important events, including DoLS authorisations, as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives had the opportunity to attend meetings and engage in surveys to feedback about the care provided at the service. A person told us, "We do have meetings to talk about things."
● The provider informed relatives that were present at the last meeting, in July 2023, that they were installing CCTV cameras in all communal areas. However, only 7 relatives were present and no other consultation or attempt to gain people's consent was evidenced. The provider told us they would address this, consulting and gaining appropriate consent from people, and relatives where relevant.
● Staff meetings were held regularly, when the provider and registered manager could discuss updates, and areas to improve and staff were able to raise concerns and share ideas.
● Although the provider had undertaken satisfaction surveys with people, relatives and staff, they had not produced responses detailing what they would do with the information, such as the improvements they would make. For example, some people had answered no to the question, 'Are you aware of the activities in the home'. A plan of what to do to improve this was not evident.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We had good feedback from people and relatives, who felt they were well cared for and listened to. The comments we received included, "Staff always around to listen" and "Everyone is so nice." Everyone we spoke to knew who the provider and the registered manager were. One person said, "(The registered manager) and the owner often pops in to see us."
● Staff told us the provider and registered manager were approachable and cared about the staff, including personal issues that may impact them at work.
● Staff at the last 2 inspections told us there was a bullying culture at times which meant they were not happy at work. Staff did not report this at this inspection and were now happier at work as this was not a concern anymore. Staff said team working was good. One staff member said, "Management here is very supportive, but we also ask each other to swap shifts so if I'm tired or something someone will pick up and cover me and I'll cover them back."

Working in partnership with others

● The provider and registered manager had made use of local networks, including the local authority and skills for care. Learning from different organisations is an area that could be improved further to support and sustain continuous improvement.
● People were referred to health care professionals and the service had a close working relationship with the GP.

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 duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. We found that the provider and management team had been open and honest, and understood their responsibility to comply with the duty of candour.
● Staff gave honest information and suitable support and applied the duty of candour where appropriate.

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 The provider continued to fail to put into practice the requirements of the MCA.

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 The provider continued to fail to assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks.

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 continued to fail to operate a robust quality assurance process to understand and have oversight of the quality of the service and ensure any shortfalls were addressed.