Moundsley Hall Limited

Buckingham House

Inspection report

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Date of inspection visit:
13 September 2023
14 September 2023
20 September 2023
26 September 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Buckingham House is a nursing home providing personal and nursing care for up to 60 people. At the time of inspection there were 46 people using the service.

People's experience of using this service and what we found
People did not receive safe care and treatment. Risks and care needs were not always identified and actions to lessen risks not taken.

People did not always have their clinical needs met effectively. Instruction from health professionals was not always followed leaving people at risk of further health complications.

The environment was not always safely maintained and risks to people's safety not always identified or rectified.

People did not always receive care that was personalised to their individual needs.

Infection control was not effectively managed.

There was no clear management governance or oversight of the service.

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 24 April 2019).

Why we inspected
The inspection was prompted in part due to concerns received about how people's needs were being managed. A decision was made for us to inspect and examine those risks.

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.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

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

Enforcement and Recommendations
We have identified breaches in relation to safeguarding people from abuse, person centred care, management of risks, safe premises and management and governance of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 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 of 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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Buckingham House

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.

Inspection team
The inspection team consisted of 2 inspectors and a specialist nurse advisor on the first day, 2 inspectors and an Expert by Experience expert by experience on the second day and 2 inspectors on the subsequent 2 days.

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
Buckingham House 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. Buckingham House 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.

There was also a home manager who was not registered with CQC but oversaw the day to day running of the service. This manager is referred to as the 'home manager' in this report.

Notice of the inspection
This inspection was unannounced.

Inspection activity started on 13 September 2023 and ended on 26 September 2023. We visited the location's service on 13, 14, 20 and 26 September 2023.

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 (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 7 people who used the service and observed how other people were being supported. We spoke with 9 members of staff including senior operational staff, the registered manager, nursing and care staff. We also spoke with an agency nurse and a health professional who was visiting the service. We reviewed a range of records. This included 9 people's care records and multiple medication records. We looked at 3 agency staff profiles and 3 staff files in relation to safe recruitment. We reviewed a variety of records relating to the management of the service, including policies, procedures and safeguarding incident records.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The provider had systems in place to safeguard people from the risk of abuse including the training of staff in how to recognise and report abuse, however the systems and processes were not applied effectively meaning people were at risk of avoidable harm.
- There was no organised system for staff to handover concerns and ensure that people were protected from abuse.
- One health professional told us that they had responded to a call from a nurse with concerns over a person's health. Instruction was given to ensure that clinical information was available, so the person could access the appropriate medical treatment. This had not been carried out and no record had been made of this instruction. As a result, the person had a prolonged period of time without the appropriate treatment, meaning their needs had been neglected.
- An ambulance crew who attended to the service raised safeguarding concerns. The concerns included reports that staff were disinterested upon arrival of the ambulance and on their phones with no knowledge of the person's history or when they became unwell, showing no urgency for the person's care even though the ambulance was in attendance. They also reported the person's bed sheets being soiled.
- One person using the service told us how they had called for assistance with personal care, and it had taken 30 minutes for a staff member to attend. They were then told that it would require an additional staff member to assist with mobility to the toilet. The person was then left for an additional 30 minutes, by which time when the 2 care staff attended it was too late. The person told us how this made them feel embarrassed and upset. This was neglectful of this person's needs.
- There was not always consideration for the needs of service users' and their associated health conditions. Where medicines were being recorded on people's medicine records as being out of stock, there was no action to ensure the person continued to receive their prescribed treatment. Actions had not been taken to identify and record people's care needs, meaning people's needs were being disregarded.

The provider had not taken action to protect people from abuse and improper treatment. This was 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.

Assessing risk, safety monitoring and management, Preventing and controlling infection

- The provider had failed to assess or lessen the risks to people who used the service.
- One person had been assessed as having specific needs around managing their mental health. When we looked at this person's care records we found there were no care plans or risk assessments.
- One person had a diagnosis of epilepsy and had lived in Buckingham House for a number of years. When we looked at this person's care records there was no information regarding seizures or what to do in the

event of a seizure. Staff, including the manager, could not tell us what to look out for or what response was needed to keep the person safe in the event of a seizure.
● Environmental risks associated with people's care and support had not been assessed or lessened. This left people at risk of significant injury.
● Areas of the home were not secure and contained COSHH. Bathrooms that were not in use were in poor repair and being used as storage rooms. A store cupboard had exposed wiring and falling ceiling tiles. One person was using a bed which had been condemned as the motor no longer worked. Window restrictors were not fitted in accordance with regulation, meaning they were not fit for purpose. One window did not have a window restrictor even though this area could be accessible to people in the home and opened onto a flat roof from a first floor, meaning there was a risk to people. We raised this with the registered manager and home manager on the first day of inspection, however it was only by the 4th visit by CQC that this had been actioned.
● Fire safety management was unsafe. Staff had not received training on fire safety. Staff could not describe the actions they would take in the event of a fire. The storage of equipment in disused bathrooms, as well as the condition of the fabric of the building with loose wiring visible, presented a fire hazard. Staff were not clear how to evacuate people with high moving and handling needs in an emergency. There had been no recent fire drills or evacuations (the last recorded fire drill was February 2023). A subsequent inspection by the fire service has found concerns and has served a fire enforcement notice on the service with a list of actions that require urgent attention by the service to make it safe.
● Wound care management was ineffective. One person using the service had a poorly fitted dressing that was incorrectly placed and restricting blood flow on their legs. The wound was also offensive in appearance and smell and was discharging onto the person's clothes. Action had not been taken by the nursing staff to address this and it required intervention from the specialist advisor to make the person comfortable and ensure that the dressing was fitted correctly.
● The management of infection prevention and control (IPC) was ineffective. Where external professionals had raised concerns that a service user required a COVID test, this had not been carried out and steps had not been taken to protect other people from the risks associated with any potential outbreak. Where people had reported being sick, or having loose bowels, no measures had been put in place to prevent the spread of a possible infection or virus. There was no clear management or oversight of infection control risks, and controls to prevent the spread of potential infections were not implemented effectively.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider had taken steps to make the environment safe. New locks had been purchased and steps taken to ensure areas were secure.
● The provider was working with the fire service to identify the actions needed to meet fire requirements.
● The provider had taken steps to review and document any wounds or outstanding health needs of people in the service and had commenced liaising with the relevant health professionals.

Using medicines safely
● The management of medicines was not always safe.
● People did not always receive their medicines in line with their prescribed needs. A lack of management and oversight of medicine stock levels had resulted in one person missing the last 7 doses (as of 14/09/23) of a medicine to treat an identified heart condition, also another person with what the manager told us was a long-standing eye condition not getting their prescribed eye drops for the last 17 doses (as of 14/09/23).
● Medicines were not always stored safely. On 14 September 2023 inspectors found an unattended

medicines trolley with a pot containing 13 tablets in an area where people who used the service could access unaccompanied. This placed people at risk of taking medicines that were not prescribed for them.
● People's medicines records did not contain photographs to identify who was to receive the medicines. There was a use of agency staff including nursing staff, who did not know people in the service by sight. Some staff told us that they had to rely on asking other staff to identify individuals in the service. This increased the risk of people receiving other people's medicines.

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

● Following the inspection the provider told us they were undertaking a root cause analysis of the incidents where people had missed their medicines. They were also seeking pharmacy support to improve the management of medicines.

Staffing and recruitment
● Staff were not always deployed effectively to ensure that people had their needs met in a timely manner. We observed times when staff did not respond in a timely way to requests for help, and people and relatives told us of prolonged periods of time before call bells would be answered.
● The provider had recruitment processes to ensure staff were of a suitable character. Staff files showed recruitment checks included checks on staff through the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, during the inspection it was identified that a member of staff employed and working in the role as a nurse had not renewed their PIN number with the NMC (Nursing and Midwifery Council). This is a legal requirement in order to work as a nurse. The provider had allowed the staff member to continue in their role as a nurse even though assurances had not been gained as to their registered status and was on the rota as a registered nurse on 9 and 10th September 2023.

The provider was not taking adequate steps to ensure fit and proper persons were employed. This was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Following the inspection the provider had suspended the nurse and was seeking advice from the NMC with regards to next steps.

Learning lessons when things go wrong
● The provider had systems to learn lessons when things went wrong, however these systems were not always effective in ensuring that actions were always identified in a timely way.

Visiting in care homes
● There were no restrictions to visiting at the time of the inspection.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support, Supporting people to eat and drink enough to maintain a balanced diet, Adapting service, design, decoration to meet people's needs

- Clinical instruction in response to concerns being shared with health professionals was not followed. Staff had contacted a health professional on 12 September 2023 to raise concerns that a person who used the service was 'chesty'. The health professional gave the nurse an instruction to undertake clinical observations and also to perform a COVID test on the person, and then to contact the paramedic so an informed decision could be taken as to the best course of treatment. This had not been carried out and it was only on 13/09/2023, did the paramedic visit and carried out the required clinical observations. The concerns for this person were not recorded in their care notes or on handover documentation that would be relied upon by staff starting a shift.
- A health professional had fed back to the local authority that their advice around a suitable bed and mattress was dismissed by the nurse they were advising, and subsequently had not been actioned in line with their advice.
- One person's clinical observations showed that at 12.37pm on the 16 September 2023 they had a 'sats' (blood oxygen saturation) reading of 82% and were experiencing 'a shortness of breath' and 'experiencing pain when touched her chest'. Staff did not call 999 and called 111 instead, only when the symptoms were explained to the operator was an ambulance called and the person admitted to hospital later the same day. This caused a potential delay to treatment, and did not demonstrate the degree of urgency the situation required. NHS England (2020) advise that if blood oxygen levels are 94% or less to contact your hospital immediately or call 999.
- Management of thickened fluids and soft diets was unsafe. A person was observed being supported with a pureed meal and thickened fluids. There was no information available in their care file regarding the required consistency or why they needed to have a modified diet. The person was observed to not eat the pureed food, no alternative was offered and the person's weight records indicated a weight loss of 12 kg since April 2023. There was no information for staff readily available about who required a modified consistency diet and staff were unable to inform us either.
- Not everyone using the service had care plans or risk assessments regarding their eating and drinking needs and preferences.
- There was no consistent action taken to ensure that where people were identified as requiring fluids to be monitored, they were getting sufficient fluids. One person had seen a doctor due to periods spells of confusion and hallucinations. The care records showed that fluids were to be encouraged and monitored, however of 32 entries of fluid intake 28 were below the NHS recommended daily intake of 1200ml, with a

recording of 0 fluid intake on 23 August 2023, and only 70ml on 24 August 2023 . This meant the person was at risk of dehydration.
● The building layout provided people with access around their environment and provided space for the use of hoists and other specialist equipment. However, the environment was not well maintained, we saw there were bathrooms out of order but remained accessible to people, areas that posed a risk of injury unsecured and broken and unused equipment stored in areas of the home. There were areas with exposed wiring and areas of ceilings where the tiles were missing. Areas secured with keypads could be accessed by going into the lift, so bypassing the doors designed to keep areas separate and secure.

The provider had not taken all reasonable steps to ensure that people were protected from unsafe care and treatment. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care records were not always person centred. Whilst assessments contained information about protected characteristics, for example gender and faith, some people's care plans and risk assessments lacked information about people's individual choices, likes or dislikes. While for some people there were no aims or aspirations about goals to achieve with individuals and this meant that people did not always experience care that was tailored to their individual needs.
● Key information about people's needs were missing from their care records. For example, two people who had been assessed as being at risk of self-harm and had no care plans or risk assessments to inform staff about how best to support them.
● Clinical instruction from health professionals was not always followed. This meant that care was not always delivered in line with people's identified needs and treatments.
The care and treatment that people received was not always reflective of their needs and did not reflect an approach that was always person centred. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider had systems to monitor staff training and identify where staff needed to update their training. There was also a system of induction for new staff, however the level of experience, competence and skills of nurses and agency staff did not demonstrate understanding of clinical responsibility.

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).

When people receive care and treatment in their own homes an application must be made to the Court of

Protection for them to authorise people to be deprived of their liberty.

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.

● Applications were made to the relevant authorities to deprive people of their liberty, and there was a system to track and identify when a DoLS needed to be renewed.
● Concerns had been raised regarding the application of the principles of the MCA. A best interests assessor had concerns a person deemed to have capacity by the manager did not have in their professional opinion and this was subsequently backed up by a doctor.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. 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; Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect. One person told us how they had been left waiting for personal care until it was too late, and that this had made them upset. A relative told us how call bells were slow to be responded to. Another relative told us how male staff had started to support their relative, and that it had been raised that there was a preference for support from female carers. They felt they had not been listened to and support by male staff had continued.
- One person said, "They do care and I get to do things." We saw this person doing artwork, which they told us would be displayed in the home. Although positive, this was not the experience of everyone in the service.

- We did see some positive interactions from staff and when they were providing care to an individual they treated them with respect, although this was at times inconsistent. For example, we observed the end of lunch in the dining area, one member of staff was assisting someone with their pudding speaking to them by name and having a laugh with them and the person was smiling. Another member of staff was assisting someone who was falling asleep and they never spoke to them. Generally, there was little interaction from staff during this time.

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

- One person told us that their choices were respected and that they had a choice over what they wanted to do, however care records lacked detail about people's views and choices. The registered manager was not able to demonstrate to us how people were involved in their care and care records also lacked detail about how people were involved in shaping their care.

Requires Improvement

Is the service responsive?

Our findings

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

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

● Care records did not always contain the information needed to ensure care plans and risk assessments were personalised. We identified where an initial assessment had identified risks that would need specific actions to lessen the risks. This would involve planning of personalised care and ensuring the person had the necessary support, however there was insufficient information to fully understand what actions needed to be taken and what level of input the person wanted and needed as they were new to the service.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The provider had a policy on accessible information which set out the aims to ensure information was presented to people in a format that was accessible. We observed adapted communication for some people including the use of communication cards to help with identification of needs and wishes.

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

● There were opportunities for people to engage in organised activities and the staff, employed specifically for activities, tried to engage people in these activities. However, some people were in rooms with their doors shut, unable to use call bells and only getting regular checks. This increased the risk of social isolation.

● Outside of planned group activities we did not observe structure to what people were doing through the day. There was no focus on encouraging people to develop relationships or to follow individual interests or hobbies.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and we could see that complaints were responded to and responses also indicated that findings were discussed with staff in relation to lessons learned.

End of life care and support

● Information in people's care records regarding end of life wishes was inconsistent as care records did not contain the amount of detail required to accurately reflect people's views or wishes. This was not in line with

the provider's 'End of life care policy' which aims to have a 'full account of the resident's physical, emotional, cultural and spiritual needs, and wishes'. The policy stated they aimed to 'ensure the end of life care of every resident is assessed and delivered to the highest possible standards.'

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 good. 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.

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

- Although the provider had systems such as audits and checklists in place and in operation at the service, they were not used effectively to keep residents safe.
- The provider did not have an effective system to assess, monitor and reduce risks relating to the health, safety and welfare of service users. Where risks were identified, measures to lessen the risks had not been implemented.
- Checks and audits in place were ineffective. For example, the concerns we found with medicines were only identified by inspectors during the inspection. No action was planned or had been taken to ensure that the impact on the people who were missing medicines was explored. Staff were supporting people with complex needs with no care plans or risk assessments to refer to. Fire checks and fire safety had not been reviewed and significant issues had been identified by the fire service.
- Where there had been a lack of clinical action and oversight of actions requested by health professionals, this had continued and increased the risks to the health and welfare of people in the service.
- The registered manager told us they had been working as the 'facilities manager' across the whole of the care village site and this had meant they had taken 'a step back from being the registered manager', having infrequent visits into Buckingham House. Whilst operationally there was a home manager, the lack of effective communication and systems meant there was a lack of governance and management overview from the registered persons.
- The issues identified during the inspection had not been identified by the provider and ineffective management and governance systems meant that continuous learning and improvement was not taking place.
- The provider systems had not ensured care records were always fit for purpose. For example, On 12 September 2023 one person's care records stated at 12:07 'amount consumed: less than half' of lunch in bedroom with family, then at 12.21 'amount consumed: All' of lunch in the dining room, however the person was in hospital at this time. This record of the nutritional intake was not accurate. There was no information for staff readily available about who required a modified consistency diet and staff were unable to inform us either.
- Where the home manager had knowledge of potential COVID they failed to take effective action, leaving people at risk.
- Staff members were not effectively undertaking their roles and responsibilities and there was a lack of provider and management oversight to ensure ongoing competence. Staff did not take responsibility for their work and did not demonstrate they were competent to perform their roles.

● The provider's systems had failed to identify and ensure that proportionate action was taken to make sure staff had the competence to carry out their roles safely and effectively. There was a lack of understanding and action to ensure that clinical care was provided with the rigour and attention required. For example, where people were missing medicines to treat long term conditions, failing to record and handover key information related to people's treatment, and staff not being accountable for their individual actions in relation to the overall care and treatment of people in the service.
● There was no clear system to effectively measure the compliance of with the providers own training requirements. Information was contained in more than one system meaning there was not a complete overview of staff competence, knowledge and skills.

The provider's systems and processes had failed to robustly assess, monitor and improve the quality and safety of the services and assess, monitor and reduce the risks relating to the health, safety and welfare of service users. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Feedback about involvement and engagement was mixed. Some people told us they had contact with the home manager and felt the home manager and provider were approachable. Some relatives didn't feel listened to and felt reviews did not happen regularly. We did not find clear evidence of consistent involvement of people in their care and treatment.
● The home manager told us about 1 person who had 'almost daily episodes of anxiety' and we were also told this person had previously indicated a wish to cause themselves harm. The manager told us there had been no care plans around how to manage the person's anxiety and no current involvement with the person to look at effective strategies to manage their anxiety. This did not demonstrate an approach that engaged and involved the person in their care.

Working in partnership with others
● Whilst the staff and management referred to and worked with other professionals, advice and instruction was not always followed and this meant people were at risk of harm.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider has provided an action plan and has showed a commitment to addressing the concerns.
● The registered manager understood their responsibilities under the duty of candour. Relatives we spoke with felt the registered manager responded to any concerns and they felt listened to.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was not taking adequate steps to ensure fit and proper persons were employed.