The Royal British Legion

Halsey House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Halsey House provides accommodation, nursing and personal care for a maximum of 89 older people, some of whom may be living with dementia. The dementia unit is a separate unit from the main building, which holds provision for people requiring nursing and residential care. At the time of the inspection there were 75 people living in the home.

People's experience of using this service and what we found
Quality assurance systems were not always effective in identifying shortfalls and improving the service. Contemporaneous records were not always accurate and up to date. The provider had failed to identify notifiable incidents.

Environmental risks to people were not always assessed, identified and mitigated. Medicines were not always administered as prescribed and recording was not always consistent. Care plans did not always accurately reflect current risks to people. Incidents were not always reported to the management team and to relevant safeguarding authorities when there was alleged abuse between people using the service. There was inconsistent recording to show how people were supported to eat and drink enough.

There were times that people went without the care they required. Care plans were not always reviewed effectively and updated in line with people's needs. They did not always contain sufficient guidance for staff on some areas of people's needs, such as behavioural, emotional and mental health support. There was not always sufficient provision of activities for people who preferred to stay in their rooms, were cared for in bed or who lived with dementia.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, there were areas where improved recording was needed and ensuring mental capacity assessments were carried out in all necessary cases.

Staff received training relevant to their roles and felt supported by the management team.

Staff adapted their communication and engaged in a caring way towards people, respecting their dignity and privacy. People felt they were listened to.

There were end of life care plans in place.

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

Rating at last inspection (and update)

The last inspection carried out was a focussed inspection on the key areas of safe and well-led. We did not inspect the remaining three areas. The overall rating for this service was Requires Improvement (published November 2018) and there were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

The previous comprehensive inspection was carried out in September 2016 (published March 2017) and the home was rated Good.

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

Enforcement
We have identified breaches in relation to safe care and treatment, governance, and notifiable events at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Halsey 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 Care Act 2014.

Inspection team
The inspection was carried out by four inspectors and an Expert by Experience. One of the inspectors was a medicines inspector. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two inspectors visited on the second day of the inspection.

Service and service type
Halsey House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was on long term absence, and the home was being managed by a peripatetic manager from another of the provider's services, along with a further manager and two deputy managers.

Notice of inspection
This inspection was unannounced. The first day of inspection was unannounced, the second day of the inspection was announced to the acting and peripatetic managers.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work 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 seven people using the service and two relatives. We spoke with 13 staff members including two deputy managers, a manager, the peripatetic manager, two kitchen staff, the physiotherapist, an activity coordinator, a nurse, two care staff, two senior care staff. In addition, we spoke with six members of care and nursing staff specifically about medicines and observed medicines being given to people. We also spoke with a visiting health professional.

We used the Short Observational Framework for Inspection (SOFI) on the dementia unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. In addition, we observed further interactions between staff and people, and observed a shift handover.

We reviewed a range of records. This included eleven people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff training records. We also reviewed a variety of records relating to the management of the service, including audits.

After the inspection
Following our inspection feedback, the provider sent us an action plan of what they had put in place immediately following the inspection visits, as well as further improvements they planned to make.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

- Environmental risks to people had not been considered, assessed or mitigated. This included a stairway with a potential obstacle of lifting a metal bar across the top, and access to items unsecured in activities rooms and kitchens, as well as items in communal areas throughout the home.
- There was no consideration of potential risks within people's bedrooms and ensuites, such as access to razors, personal toiletries, and denture cleaning tablets. Medicines prescribed for external application such as creams and emollients stored in people's rooms were not secured so they could be accessed by people who could have caused themselves accidental harm. This included in the unit where people lived with dementia.
- Bed rails had been risk assessed when they were in use for people. However, we saw that many people had bed rails which were integral to their beds. These had not been risk assessed because they were not supposed to be used. However, there was a risk that unfamiliar staff would use these inappropriately (automatically) because they were attached to the beds.
- We found mixed recording around risks to people throughout the home. In some areas, care plans recorded risks clearly, such as those around people's skin integrity and health needs. In some care plans however, due to inaccurate recording, it was not always clear what current risks applied to people. For example, we saw a record for one person's pressure sore, with no date.
- When people were no longer being weighed, in their best interests due to deteriorations in their health, there was not always further consideration of reviewing their likely weight loss, for example using upper arm circumference. This meant staff could not assure themselves of whether these people continued to lose significant amounts of weight or not.
- Care plans were not always properly reviewed and updated to reflect people's current care needs. For example, the summary care plan did not always contain recently prescribed medicine, such as additional pain relief and eye drops, and people's up to date nutrition and hydration needs. One person had inconsistent doses of thickening agent written in their care plan summary which presented a risk of choking if followed. This presented a risk that staff could follow incorrect guidance.
- Accidents and incidents were not consistently recorded, and had not always been consistently and effectively reviewed. From records we reviewed, incidents that were recorded on people's daily behaviour charts were not escalated or reported to management. Therefore, there was a lack of improvement to the service in learning from incidents.
- During the inspection we made the management team aware of several reportable incidents we identified from reviewing people's care records, which posed a risk to safety for people living in the home.
- Members of staff handling and administering people's medicines had received training. However, they had

been not been re-assessed for their competency to handle and give people their medicines safely within the homes' stated timeframe and in line with best practice.
● Observations of staff showed they were sometimes interrupted by other members of staff which could have led to errors.
● There was no process in place to show how long prescribed creams with shorter shelf-lives had been in use once opened.
● Oral medicines were stored securely. However, some medicines requiring refrigeration had been stored at temperatures below the accepted temperature range which could have led to the medicines being unsafe to use.
● We saw that one person had not received their eye drops for a period of 16 days because it had not been obtained. At the time of inspection, the person told us they had deteriorating vision. We asked the provider to take urgent action to obtain this medicine, which they did. This matter was only addressed due to the inspection team requesting for urgent action to be taken.
● There was guidance to help staff give people their medicines prescribed on a 'when required' (PRN) basis for some but not for all medicines prescribed in this way. Some of the written information lacked sufficient detail to enable staff to give people these medicines consistently and appropriately. In addition, there were not always clear records showing why the use of the medicines was justified on each occasion. This included for people who were receiving regular PRN psychotropic medicine without recorded explanation each time it was administered.
● Some PRN medicines did not have full associated care plans, for example for one person who was prescribed PRN laxative medicines, there was no guidance around constipation in their care plan. The nurse we spoke with told us when they would administer this, although this was not recorded. We saw from records that it had not been administered according to what they told us.
● When PRN medicines were given, there were not always records of the reasons they were administered at the time of administration.
● Some people managed some of their own medicines, however, staff were not frequently reviewing the risks around this to ensure that people continued to be able to do this safely.
At our last inspection 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. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.
The provider responded during and after the inspection to some of our concerns. They confirmed all the actions from our concerns around medicines were completed on the second day.
Systems and processes to safeguard people from the risk of abuse
● Staff were not always aware of their responsibilities in reporting certain incidents to safeguarding authorities. We found a number of incidents of behaviours between people living in the service which were reportable to safeguarding authorities because they involved alleged abuse. These incidents had not been identified as alleged abuse. Therefore, no further action was taken to ensure the relevant authorities were aware to safeguard people.

Staffing and recruitment
● People told us staff were available when they needed them. One person said, "I really don't have to wait long if I need help."
● Although people's dependency was assessed in terms of their physical care requirements, this did not take into account people's behaviours and how this may impact on staff time needed. Dependency assessments did not include details such as extra time for supporting people with snacks in between meals.
● Staff told us that although there were enough staff to cover shifts and meet people's needs, at times difficulties were posed by working with agency staff who were not familiar with the home. Staff told us there

were times when shifts were much harder for the regular staff due to this.
● The service continued to maintain safe recruiting practices. This included ensuring new staff had undergone checks such as the DBS (Disclosure and Barring services) and references.

Preventing and controlling infection
● The home was clean and there were regular checks in place to monitor infection control standards.
● Staff received training in infection control and had PPE (Personal Protective Equipment) available to use when delivering personal care.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was not rated. At the last comprehensive inspection, it was rated Good. At this inspection it has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- We found at the last inspection that there was not always consistent recording and oversight of people's food and fluid intake. We found this continued to be the case. For example, some people's daily fluid intake was very low but there was no evidence of establishing a daily fluid target. The service continued to lack oversight of people's hydration needs.
- There was inconsistent recording around food and fluids. Records showed when people refused their meals, however these people were not always offered further snacks in between meals. This included people who had lost weight and were at risk of malnutrition.
- Where people were at risk of weight loss, it was not always recorded what they had eaten, which would help staff to establish preferences. This was also the case for people who were not ableel to verbally express themselves. Records were not always completed for some days to show any meals eaten or refused.
- Kitchen staff were knowledgeable about people's dietary requirements, and there was a choice of meals available to people. One person told us after lunch, "Yes it was very nice. I wasn't bothered about either of the main courses so they made me a salad, it was lovely."

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

- The staff worked closely with the local GP surgery, but had not always made full use of this relationship. The nurse practitioner who visited the service daily had not always been consulted around concerns around people's wellbeing related to medicines not being available when needed.
- We saw evidence of healthcare professionals being involved with people's care, for example, physiotherapists, speech and language therapists and chiropodists.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- We found that current pre-assessments did not fully cover areas of people's care such as emotional and mental wellbeing. This information should be used to create a full care plan. For example, we read in one person's care summary that they suffered with anxiety at times, but this was not covered in an associated care plan with guidance for staff.
- Where people came into the home on respite, their mental health, emotional and social needs were not covered in the preassessment. For one person we checked, their preassessment covered only their medical history and mobility equipment. This presented a risk that important care needs may not be identified, and management plans put in place
- A deputy manager showed us a new and improved form which they were beginning to use to assess

people's suitability to live in the home.

Staff support: induction, training, skills and experience
● People and relatives felt that staff were competent. One person said, "They seem well trained to me, I think they know what they're doing."
● Staff told us they had training in areas such as manual handling, first aid, dementia and infection control. Where there were any specific concerns around a person's manual handling, staff involved the physiotherapist and occupational therapists in reviewing their needs.
● A deputy manager told us about the induction process, which included at least two weeks shadowing more experienced staff across the different units in the home. It also included mandatory training and undertaking of the Care Certificate. This is a qualification outlining an expected set of standards in health and social care.

Adapting service, design, decoration to meet people's needs
● The service was designed in a manner that met people's needs, with a wide range of communal areas for people to access, such as lounges, a bar/café area, a large conservatory area, communal dining rooms on each unit, and activities rooms.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● There were mental capacity assessments in place for some decisions for people, but not all. For example, the use of medical interventions had not always been considered in mental capacity assessments. There were no records of mental capacity assessments or best interests' meetings for decisions made around the frequent use of PRN ('as required') psychotropic medicines.
● Where best interests' decisions had been made for people, for example around a sensor mat being in use, there were not always records of family or other professionals being involved or consulted about these decisions, in line with the legislation.
● Staff asked for consent before delivering care. One person confirmed this by saying, "They ask first and then explain what they want to do and often they'll tell me why."

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was not rated. At the last comprehensive inspection, it was rated Good. It has deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- There was not always a caring culture due to the management systems in place. People at times went without the care they needed, thus negatively impacting on their quality of life.
- People who presented with distressed behaviours, such as crying out, were not consistently supported and reassured. Full guidance around supporting people with emotional symptoms was not in place for staff on how best to support them. One staff member told us how they reassured a person who regularly became distressed, but this was not recorded in the care plan. Staff therefore could not consistently support the person with their emotional needs.
- People felt they could talk to staff and were listened to. One person said, "Yes, we have a bit of a laugh and if I was worried about something I'd be happy to talk to any of them." A relative said, "I've noticed all the carers seem to know [relative] and smile and say hello to her when she's out and about. When they come in, they don't just do their job and leave but talk to [relative] and spend a little time with her. The nurses always kneel down so they're level with her."
- We saw some caring interactions taking place between staff and people using the service. Staff adapted their communication with people appropriately, for example getting down to their level. Staff were respectful in how they supported people to take their medicines.

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

- People told us they felt involved in decisions relating to their care, one saying, "I can say what I want. If I speak to the carers, they listen." Staff told us how they supported people to make choices about their care, for example what they wanted to wear and eat, and when they wished to have a bath or shower.
- We saw that where there was a concern about someone's health, for example if they had developed a pressure sore, that family members were informed.

Respecting and promoting people's privacy, dignity and independence

- People felt their dignity an privacy was respected; one person confirmed, "I need some help to get dressed and I've always found the carers very respectful."
- We saw that care staff knocked on doors and ensured they put out a 'do not disturb' sign on the door when supporting people with personal care.
- The physiotherapist was available to support people to increase and maintain their mobility where possible, which further maintained their independence. An occupational therapist was also available fortnightly to support people, for example, with equipment they required to be as independent as possible.
- People's care plans outlined areas where they were able to be independent in their own care needs.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was not rated. At the last comprehensive inspection, it was rated Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- There was not always personalised care in place. Where people had regularly presented with emotionally distressed behaviours, or behaviour which may be challenging to others, there were no care plans in place or guidance for staff around this. There was a high use of agency staff who were unfamiliar with people's needs.
- Incidents had not always been reviewed and used to update or inform a care plan to meet people's needs. For example, one person had displayed aggression towards other people and staff. There were no recorded explanations for this in the care plan, although one member of staff was able to inform us of some triggers and how they supported and reassured the person. There was no recorded guidance on how staff should support the person physically or emotionally when they presented with these behaviours. This meant that unfamiliar staff, such as agency or new staff, did not have enough guidance to support people.
- There was not always sufficient detail in people's records to show what care they had received in line with their care plan, for example, if they had daily exercises prescribed, or support with oral healthcare.
- Staff did not always deliver care according to people's care plans. For example, on two occasions we saw one person walking around unsupervised by care staff and without their mobility equipment, contrary to their care plan and placing them at increased risk of falls.
- During our SOFI on the dementia unit, we observed little interaction between staff and people, and most people in the communal lounge area were napping.
- People and relatives told us staff responded to people's requests for support in a timely manner. One person said, "I had a fall a few months ago. I was cleaning my teeth and managed to flick some into my eye. I reacted by moving back and just fell over. I remembered to press the call button and the carers were there in an instant." A relative said, "The carers regularly check on [relative]. They come in and have a little chat with her. I find that reassuring."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans did not always contain guidance for activities and occupation. When people preferred to stay in their bedrooms or were cared for in bed, there was little evidence of staff offering participation in social activity or stimulation. This presented a risk of social isolation.
- A list of activities on the unit where people lived with dementia included, 'baths and showers', 'listening to music' and 'watching television'. These did not constitute meaningful occupation or person-centred activities.

● For people who were able to join in group activities in the home, there were various options available. One person told us, "I enjoy the quizzes and some of the musical things; oh yes, and I go to the bingo sometimes." We saw a musical entertainer and some people being supported with colouring during our inspection visit.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Accessible communication standards were in place, including provision of information in large print and guidance in care plans for staff. There was appropriate signage around the home to aid navigation and promote independence.

Improving care quality in response to complaints or concerns
● The provider had taken steps to use feedback from meetings for people using the service, to take actions on requests bought forward. For example, they introduced certain foods people requested in these meetings.

End of life care and support
● There were comprehensive end of life and advance care plans in place which identified aspects of care which were important to people reaching the ends of their lives. This included how and where people wished to be cared for, and who they wished to be involved.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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

- The registered manager was not working at the time of the inspection due to prolonged absence. The management team consisted of two deputies, a peripatetic manager and a further supporting manager from another service owned by the provider. The two supporting managers had been in the home supporting for a approximately four weeks. Therefore, there was not a consistent and stable managerial oversight of the service.
- There were not always accurate, contemporaneous records around people's care needs. Records were not always dated and consistently completed. Care quality reviews were not always meaningful and accurate.
- Following a serious incident in the home last year, the provider had concluded an internal investigation and stated what learning and improvements should be put in place to ensure people's safety in the home. We found that not all these were being adhered to. For example, staff were not recording times of night checks, which had been decided as an action going forward. The 'resident of the week' audit form was not always complete and showing that all agreed checks were carried out. This included the checking of window restrictors following the serious incident.
- People continued to be admitted into the home without full comprehensive preassessments which included their mental and emotional wellbeing and without assessing their suitability in line with the provider's internal investigation improvement plan.
- Not all issues we identified had been found by the provider. These related to the management of medicines, identification and mitigation of environmental risks to people, accuracy and quality of care plans and the management of incidents and challenging behaviours.
- Care file audits were not fully effective as they did not identify where there were inconsistencies, or where people's needs had not been fully and holistically planned for. It had not been identified where risks to people were not properly assessed and mitigated, or where people did not have care plans for activity and sufficient behavioural and emotional support.
- Audits had not always been dated so were ineffectual. When they were dated, dates were not always accurate. For example, one care file audit date was 4 September 2019, which was three weeks after our inspection visit.
- Where audits had identified shortfalls, these were not always resolved. For example, a medicines audit carried out in July 2019 had identified that there were, 'shortfalls' due to stock problems. This had not been rectified as we found there continued to be shortfalls in medicines stock in August 2019.
- A report carried out in March 2019 identified a lack of interaction between staff and people on the dementia unit, and no further action had been taken to make improvements.

● Some shortfalls we found had already been identified in a recent check by the local authority. This included the medicines fridge temperatures and missing food and fluid targets. No action had been taken despite being informed of these shortfalls prior to our inspection visit. This demonstrated that the provider did not always take a proactive approach in response to risks and concerns.
● Due to ineffective quality assurance systems and oversight of the running of the home, there was a lack of continuous learning and improvements to the care provided.

At our last inspection the lack of consistent management and oversight meant that shortfalls in the service were not sufficiently identified and acted upon. This meant there was a breach of Regulation 17 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 regulation 17.
How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not been made aware of incidents which had involved alleged abuse between people using the service. There was no evidence to suggest that family members were made aware of these incidents in line with the service's duty of candour.
● We found some incident forms relating to falls which had resulted in head injury had not been notified to CQC.

At our last inspection we found we had not always been notified of events when needed, resulting in a breach of Regulation 18 of CQC Registration regulations.

At this inspection we found there were outstanding notifiable incidents and the provider was still in breach of the above regulation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us they felt listened to. One staff member said, "[Management team] are very understanding here, if you have a problem if you go to them, they listen to you and they support you."
● There had been recent improvements in involving people who used the service, which included meetings for people living there. The management team had then developed a 'you said, we did' document to show how they had acted on feedback.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We saw that the staff team generally worked well together, but some practices among the staff team were not in line with promoting an open and caring culture. We fed back concerns from our observations of poor practice to a deputy manager during our inspection visit.

Working in partnership with others
● The home had not taken full advantage of working in partnership to improve care for people, for example working in consultation with dementia specialists when people's needs changed.
● The home worked closely with two staffing agencies to ensure they obtained additional cover in the event of staff absence, and ensured they obtained the same staff where possible.

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 18 Registration Regulations 2009 Notifications of other incidents Not all incidents were notified to CQC as needed. 18 2 (b) and (e)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 Environmental risks to people were not always assessed, identified and mitigated. Medicines were not always administered safely. Care plans did not always accurately reflect current risks to people. 12 (1) (2) (a) (b) (d) (f) and (g)

The enforcement action we took:

Conditions imposed on the provider's registration

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 Quality assurance systems were not effective enough to identify shortfalls and lead to improvements. There were not always accurate contemporaneous records. 17 (1) (2) (a) (b) (c) and (f)

The enforcement action we took:

Conditions imposed on the provider's registration