Lutterworth Country House Care Home Limited

Lutterworth Country House Care Home

Inspection report

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27 June 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Lutterworth Country House Care home is a residential care home providing personal care to 52 people aged 65 and over at the time of the inspection. The service can support up to 66 people. The care home accommodates people in two floors, each of which has separate facilities.

People's experience of using this service and what we found
There were not enough care staff to meet people's needs. They did not always receive care and support when they needed it. Staff and some relatives also felt there were not enough staff. Some staff were temporary and did not always know how to support people or know their needs well.

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

People were not monitored closely enough to protect them from injury. This meant people were not always safe from avoidable harm.

Medication policies and procedures were not managed well. People's reasons for requiring certain medicines were not always recorded.

Care staff treated people with kindness, but people's dignity was not always preserved because of the level of staff available to support them.

People were protected from the risk of infection because staff followed the training they received.

People could be assured they would be protected from the risk of abuse.

People were provided access to health care services.

People had personalised their bedrooms and the communal areas were well furnished.

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

Rating at last inspection
The last rating for this service was requires improvement (published 24 October 2018).

This inspection was prompted in part due to concerns received about staffing, management of medicines, and falls. A decision was made for us to inspect and examine those risks.

The inspection was also prompted by notification of a specific incident following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident. The information CQC received about the incident indicated concerns about the management of falls and unsafe medicines management. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see all the sections in the full report for details of these.

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

The provider has in part taken action to mitigate these risks. No action has been taken in response to the concerns we identified with the staffing levels at the time of writing the draft report. However, action has been taken to support people who require medicines at night by the deployment of trained staff to administer them safely. People remain at risk following a fall as monitoring protocols are not routinely followed though the provider is working collaboratively with the local authority who are delivering training to staff to reduce the risk of people falling and what actions to take in the event of a fall.

Enforcement
We have identified breaches in relation to the staffing level at the service, how the service manages risks to people, the management of medicines, dignity and respect and the management of the service at this inspection.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The service was not always well-led.

Details are in our well-Led findings below.

Lutterworth Country House Care Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of two inspectors, a pharmacist 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: Lutterworth Country House Care Home 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.

Notice of inspection: The inspection was unannounced. Inspection activity started on the 26th June 2019 and ended on the 27th June 2019.

What we did before the inspection: The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. 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.

During the inspection: We spoke with ten people who used the service and five relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, registered manager, assistant manager, senior care workers, care workers and the chef.

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

After the inspection: The registered manager informed us that senior carers had been appointed to the night time shifts to support staff and administer medication.

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 remained the same.

Requires Improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● On the first day of our visit one agency night staff had left early leaving only one staff on the upper floor for 30 minutes. This member of staff did not alert staff on the lower floor that they were left alone and required support from them to continue to be able to safely meet the needs of people on the upper floor.

● We found it had taken until 12.00pm for people's morning care and support needs to be completed on the upper floor. On the second day of our visit it had taken until 11.45am on the lower floor. One person waited until 11.30am for breakfast and was served lunch at 1.30pm. One staff member explained, "This is because a lot of things haven't been done when we arrive in the morning and we are then trying to catch up."

● One staff member told us, "We need more regular staff, we have a lot of agency staff, at the moment it's difficult to do everything we need to." Another staff member told us, "Staff numbers are not enough, we need patience and time to support people, but we can't always do that and are just task orientated and don't have time for anything else."

● Some staff told us they had raised concerns about the staffing levels with the registered manager but didn't feel they were listened to. One staff member told us, "I don't say anything anymore, it's pointless. Unless we have more residents than we do now we won't get any more [staff]." A further staff member told us, "We need the right staff with the right training."

● One relative told us, "They haven't got the time to give the care." Another relative said, "I tested the buzzer by standing on [relatives] bedside mat and they failed to respond within five minutes. I then went into the corridor and three carers were all talking at the top of the corridor." One visitor told us, "[Person] is not always up when we get here so we have started coming in the afternoon."

● One person told us they documented they had been waiting for 42 minutes for their call bell to be answered. They said, "I got out of bed in the end to find a staff member as I needed medication."

● There was a continual lack of staff presence within the communal areas of the service throughout our inspection. People were left alone with little occupation or interaction with staff and some people were asleep for long periods.

● All of the staff we spoke with said there were not enough of them on duty to meet people's needs in a timely manner.

During our last inspection on 25 September 2018 we recommended the provider review the dependency tool used to determine staffing levels. Whilst this had been reviewed since our last inspection, and again

during this inspection, we identified continuing concerns of the number of staff deployed in the service. We reviewed the staff rotas and whilst they mostly met the planned staffing resource our observations confirmed these did not meet people's needs in a timely manner.

System in place were not robust enough to demonstrate staffing levels were effectively managed. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a suitable recruitment policy so that staff with the appropriate qualities and experience were employed.

Assessing risk, safety monitoring and management
● We found improvements were needed to how risks were managed and assessed. During our visit one person had been calling out for help for 25 minutes. We visited their room and found their call bell was out of reach, resulting in the person having to call out for assistance. We reviewed their care file and it stated that the person should always have their call bell with them. This was rectified immediately by the deputy manager.
● A sensor mat in one person's room was to alert staff when they mobilised, but it had not been placed in the correct position. This meant staff would not know if the person had tried to mobilise or had fallen. This was rectified immediately by a senior carer.
● Processes had not always been followed when an incident had occurred. One person had fallen the previous night of our inspection. We were told the providers process was to carry out hourly observations following a fall to monitor a person for any deterioration in their condition and, any healthcare treatment that may be needed quickly. Hourly observations had not been carried out and an incident form had not been completed.
● Records did not always accurately record or provide enough information when an incident occurred. For example, we were told of an incident at 10.45pm the previous evening but records stated it occurred at 11.56pm. A member of staff who was completing the incident form, but had not been on duty at the time, told us, "There is not enough information on the form for me to make an assessment. I have only been told the person had fallen and the agency staff on duty at the time has now left. It worries me."
● Whilst risk assessments were in place, not all the risks presented to people had been assessed. This included for one person, the lack of footplates being used when transported around the service in a wheelchair placing the person at risk of injury.
● We observed one person dragging themselves down a corridor whilst seated in an armchair from their bedroom. We identified this was an attempt to get staffs attention. We notified a member of the management team who went to the person's aid and made them safe.

● Systems were either not in place or robust enough to demonstrate risks to people's health were safely managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008

Using medicines safely
● The provider was not always managing medicines safely. There were not always trained staff to administer medicines overnight. This meant people requiring medicines such as pain relief could not access them at the time they needed them.

Following the inspection, the registered manager informed us they had recruited staff who could administer medicines at night.

● Medicines were not always administered in the way the prescriber intended, which could affect the effectiveness of the medicine. For example, a medicine which should be taken before food was administered after breakfast. This meant the person would not obtain full benefit from it.
● Protocols to assist staff on when to administer PRN medicines were not always in place or appropriate and were not person specific for those who had difficulty verbalising when they needed their medicines. Staff were not always recording the time, reason or outcome for the person receiving the medicine. This meant the effectiveness of the medicine could not always be reviewed and there was a risk they could receive too much within safe timescales.
● Staff did not follow the providers medicine policy. People who were on medicine patches had no records of where their patch was placed on their body. People's skin could be compromised due to patches being repeatedly applied to the same area. People who were prescribed topical medicines did not have records of where to apply the medicine.
● Controlled Drugs (CDs) returns were not correctly signed out of the CD register. This meant there was potential for misuse as the records did not match the contents of the CD storage cupboard.
● Staff were not aware of or, did not follow the needles policy. We observed a member of staff administering insulin who didn't wear gloves and had not washed their hands prior to, and after administering the medication. Following administration, the staff member returned the needle to the medicines room in an open pot. A needles bin should have been taken to the person's room for immediate and safe disposal.

Systems were either not in place or robust enough to demonstrate the management of medicines were safely managed. This placed people at risk of harm. This was a breach of regulation 12(2)(a) (Safe care and treatment) of the Health and Social Care Act 2008.

● Staff were patient and considerate whilst supporting people with their medicines.
● Medication administration records (MAR) were completed and medicines were stored securely.
● Staff had up to date medicines training and their competency check however, these did not identify the shortfalls we found during our inspection.

Preventing and controlling infection
● The provider had systems in place to make sure that staff practices controlled and prevented infection as far as possible.
● Staff had undertaken training and were aware of their responsibilities to protect people from the spread of infection. They followed good practice guidelines, including washing their hands and wearing gloves and aprons.

Learning lessons when things go wrong
● Issues identified on the first day of our inspection around medicines administration had been addressed by day two. This was in relation to the non recording of where medication patches had been applied to a person's body. A form was introduced, and protocols developed to ensure patches would not be applied to the same area of a person's body on consecutive occasions.

Systems and processes to safeguard people from the risk of abuse
● Whilst not all staff had not received safeguarding training those we spoke with during our visit knew what to do if they had any concerns for people. Staff knew signs of abuse and how to report it. They felt confident their managers would take concerns seriously.
●One staff member said, "I would inform the manager, I feel they would act and take the necessary action." One person told us, "Yes I feel safe."

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

Requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People were assessed before they came to the service to ensure staff could meet their needs. Assessments included people's physical, mental, social and cultural needs.
- Staff were trained in equality and diversity and understood people's individual needs. However, some staff commented on the difficulties of working alongside agency staff as they did not know people well. No time was afforded to these staff to read people's care files. This meant people might not be supported effectively according to their assessed needs.

Staff support: induction, training, skills and experience

- We reviewed the services training programme. We found not all staff had received the required mandatory training. The registered manager informed us that arrangements had been made for this to be completed.
- Staff we spoke with who had worked for the service for some time felt they had received a thorough induction, were well trained and could meet people's care needs. However, some recently recruited members of staff said they hadn't. A staff member who had been in post for two weeks had yet to receive any training but said they felt supported by experienced staff.
- Permanent staff told us that agency staff did not always have the necessary skills to support people. We found one agency staff member did not have a profile in place. This meant the service did not know what training the person had received before they delivered care.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective and timely care

- People's nutritional needs were met, and their preferences considered. People said they liked the food. One person told us, "The food is good, and it has certainly improved over the last few months. Another person told us, "There is lots of choice for breakfast and the portions are good too."
- Staff were knowledgeable about people's preferences. The menu was varied, and staff were offering the menu to people in pictorial and written form. We observed people being offered a choice of drinks.
- Referrals to SALT (speech and language therapists) had been made to support people safely with their nutritional needs. Care files showed recommendations that had been made, were followed.
- Where people were at risk of malnutrition this was detailed in people's care plans. For example, records were completed one person who required their weight to be monitored regularly.

● Records showed people were supported to access health professionals such as GPs, opticians and district nurses. One person told us, "We have an excellent doctor who visits twice a week."

Adapting service, design, decoration to meet people's needs
● The environment was dementia friendly and there was good signage for people to orientate themselves. Corridors were designed well and contained 'street furniture'.
● People's bedroom doors were coloured with attached photos to enable them to identify their room. People's rooms were personalised and well maintained.
● The service was well furnished. The décor, furniture, carpets and curtains were maintained to a good standard.
● There was a communal area for people to socialise and participate in activities. These were clean and free from hazards. People could access a safe outside space that contained a summerhouse which housed a café.

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.

● Whilst training records showed only half of staff had received MCA and DoLS training, the registered manager had arrangements in place for the remaining staff to undertake this training.
● Staff understood the principles of MCA and gained people's consent before support was provided. For example, we saw people choosing what to eat and drink and how they would like to spend their time.
● People had been referred for an assessment to deprive them of their liberty where appropriate and any conditions were being followed.
● Care plans demonstrated good examples of seeking people's consent. For example, 'care staff are to gain consent from [person] before assisting with any transfers'.

Requires Improvement

Is the service caring?

Our findings

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

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

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 and respecting and promoting people's privacy, dignity and independence

- People were not always well cared for or treated in a dignified way. For example, some people had not been supported to brush their hair and were wearing unsuitable footwear. One gentleman had a lady's slipper on and another person had no laces in one shoe. Further observations included one person who was brought to the dining room with no shoes on. A senior staff member did notice this and provided the person with shoes.
- A staff member identified a person who became agitated when alone at the dining table. We observed staff making no attempt to spend time with the person for a considerable time.
- Some relatives we spoke with raised concerns about personal care. One told us, "Sometimes [person] nails are long and dirty. Another told us, "There is sometimes faeces beneath [person] nails. A further relative told us, "My [relative] had a headache and a temperature the other day but the staff said there was nothing wrong with."
- Some relatives raised concerns about staff. One said, "There is a lack of interest by staff. They clearly just do the basics. A second told us, "I'm not impressed. I find it a depressing place to come and the staff are not genuinely engaging with people." However, a third relative told us, "I am happy with how [person] is looked after. I would have never left [person] here if I wasn't."

This was a breach of regulation 10(1) (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We did observe examples of compassionate care. For example, one carer was gently stroking a person's hand when assisting them at breakfast. We saw one carer was communicating affectionately to a person at lunch time.
- People's comments about staff included, "The senior carers look after me well; I've got used to the carers and they're lovely; they treat me as a family; on the whole it's good although some carers need 'chivvying up'.
- Although there was a confidentiality policy in place people's records were not kept in line with the General Data Protection Regulation (GDPR). For example, the office containing people's care records was unlocked and people's care notes were being completed in a communal area. This meant people had opportunity to gain access people's personal information.

● Staff knew the importance of promoting people's dignity when delivering personal care. One explained, "We make sure doors are closed and wrap a towel around people, so they are covered."

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

● Our observations confirmed people had little choice of the timing of when they received their care. Staff confirmed this and explained this was especially so during the morning due to the lack of staffing.

● People had access to details of advocacy services and these were displayed in the service.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained requires improvement.

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

● People's care plans covered areas such as nutrition, pressure care, personal care and mobility needs. However, these were not always up to date. One person's care plan dated 31 July 2018 stated there was no turning chart in place but one was in use. Another person's care plan showed they sometimes needed the support of one carer and at other times two. Staff confirmed the person always needed the support of two carers.

●A communication, mobility and pressure care plan for one person stated, 'ensure call pendant is always accessible'. Staff confirmed the person did not use a call pendant. The review of the care plan did not record this.

● A person's skin care plan stated 'District Nurse' to redress leg every two to three days. Records confirmed the nurse was visiting every ten days. This meant the care plan was either not up to date or staff were not recording the visits.

● One person had an appointment with a Paid Persons Representative (PPR) during our visit. A PPR is a professional person who acts on behalf of a person when there is no one in their life who is willing or able to act as their representative. In one care file a PPR wrote 'unsure if the care plan reflects the person's needs.

● One staff member told us additional equipment would reduce delays to people's personal care. During our inspection we were told one person was waiting for assistance to go to the toilet. Staff were unable to facilitate this as the one hoist available was in use.

● A comprehensive plan was in place for one person whose behaviour challenged others detailing the actions and triggers staff should take to reduce behaviours further.

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.

● People's communication needs were identified in their care plans. The provider could make available information to people in various ways including pictorially and large print.

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.

● Whilst regular staff knew people well their support was sometimes compromised by staff who did not know them well. People were prevented people from forming consistent relationships with all staff due to the regular recruitment of agency staff. During our visit one regular staff member was delivering meals to people's rooms whilst two new carers were in the dining room.
● One person told us, "It's not as good as it used to be. They used to employ steady local people, but it is mixed more and more with staff we don't know."
● People's care files considered people's social needs. For example, one person's file commented '[person] is quiet, likes to spend time in the communal areas watching TV and participating in some activities'.
● The provider employed an activities coordinator three days per week and people were able to take part in activities. There was a weekly schedule of events that included a visit by an accordionist, guitar vocalist and the use of Pets as Therapy (PAT). PAT enables people who appreciate being able to touch and stroke a friendly animal. On the day of our visit a PAT dog visited, and the owner knew some people's names.
● Most activities were arranged in the afternoons. On the morning of our visits we observed some people chatting in communal areas, but others appeared to have little stimulation or attention.
● People's relatives and visitors said the service was welcoming and, could visit at any time.
● The service took account of people's lives before they came to the service. For example, one person told us, "I had to give my dog away when I came here but they let the new owner bring her in to see me every week."

Improving care quality in response to complaints or concerns
● A formal complaints policy and procedure was in place and openly displayed. Any complaints were addressed by the registered manager and people felt assured any concerns would be taken seriously.
● One relative told us, "I previously made negative comments about some staff bit, these were generally resolved." One person told us, "Any slight problem I would go to the manager, or my [relative] would."

End of life care and support
● Although no one was receiving end of life care at the time of our visit most people's care plans showed their wishes had been explored.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same.

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

●The registered manager had systems in place to monitor the quality and safety of the service. However, the monitoring of staffing levels was not effective to ensure appropriate numbers of staff were deployed throughout the service to meet people's needs in a timely manner. Audits of the call bell system identified that 13% of the response times took over twenty minutes. Actions had not been taken to address these delays.

● Staff were not deployed effectively to meet people's needs. For example, during our visit we alerted a member of the management team on two occasions for people who needed support for prolonged periods.
● A member of the management team carried out a daily 'walk around' the service. However, this process was not effective, and did not identify concerns raised during our visit for any action to be taken.
● Staff told us the management team were not a visible presence in the service and felt they were unaware of the difficulties they had in delivering timely care. Our observations confirmed this.
● The registered manager deployed a high number of agency staff who were unaware of people's support needs. They did not have time to familiarise themselves with people's support needs. Regular staff told us their duties were delayed as they were consistently supporting new staff into the service.
● Regular audits to monitor the environment and, on the equipment used to maintain people's safety had been carried out
Systems were either not in place or robust enough to demonstrate that effective systems and processes were in place to monitor and improve the quality and safety of the services provided.

This was a breach of regulation 17(1)(2a) (Good governance) of the Health and Social Care Act 2008

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff said the management team did not respond or investigate their concerns around the resourcing of the home and, the impact this was having on people's care needs being met in a timely way.
● Staff morale was low, and their well-being was not considered. Staff told us they felt pressured and often worked for long periods before being able to take any time away from their duties. On the first day of our

visit two members of staff have not had a break for seven hours.
● Staff received supervision. However, one member of staff explained, "We have supervision every couple of months and we can share our thoughts, though we don't always feel listened to. You can approach them [management] it just takes time."
● Annual surveys had been carried out by the registered manager to gather people's views of the service.
● Regular residents and relative's meetings were held for people to share their thoughts of the service.
● One person told us they were regularly contacted by the service about their relative's care as they were unable to visit frequently.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their legal responsibility for notifying the Care Quality Commission of deaths, incidents and injuries that occurred or affected people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events.
● Staff demonstrated their knowledge and understanding around such things as safeguarding, whistleblowing, equality and diversity and human rights.
● The registered manager was aware of their responsibility to have on display the rating from their latest inspection. We saw the rating was clearly on display on the provider's website and within the service.

Continuous learning and improving care
● Where shortfalls on medicine protocols had been identified the registered manager had developed new processes and documentation.

Working in partnership with others
● At the time of our visit the registered manager was working with the local authority's quality improvement team. Falls training and best practice guidelines were being provided to reduce the risk of any incidents and how to respond appropriately.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated in a dignified way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always assessed or safely managed. Medication was not always safely managed

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	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not ensure systems and processes were effective to monitor the quality of the service, mitigate risks to people, store people's records securely and act on people's feedback.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not enough staff to meet people's needs in a timely manner. Risks to people were not always assessed or safely managed. Medication was not always safely managed

The enforcement action we took:

Warning Notice