Nazareth Care Charitable Trust

Nazareth House - Hammersmith

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?	**Requires Improvement**

Summary of findings

Overall summary

Nazareth House is a residential care home providing personal and nursing care to 89 people aged 65 and over at the time of the inspection. Nazareth House can accommodate up to 95 people across three floors, each of which has separate adapted facilities. The first and second floors specialised in providing care to people with nursing needs and the third floor was a residential floor for frail older people or those with early onset dementia.

People's experience of using this service and what we found
The provider did not keep records to demonstrate lessons were being learned when things went wrong. Accidents and incidents were recorded, but there was no record kept of how lessons were being learned to mitigate against any future risks. There had been some safeguarding concerns raised which are being investigated by another authority. The provider was working with the local authority to resolve these issues. The provider did not always ensure there were enough staff deployed to meet people's needs. Insufficient information was recorded in relation to people's mental health needs which created a risk of them not receiving the care they may have needed. The building was not suitably adapted for people with dementia as the décor was sparse and there was a lack of reference points to prompt people.
The provider did not take appropriate action to mitigate people's risk of social isolation as people's involvement in activities were not monitored and there was a lack of activities provision for people with dementia. People's relatives told us their complaints were listened to, but appropriate action was not always taken to rectify these. People's relatives told us they were asked for details of their family member's needs and preferences, but these were not being met in practise. The provider did not always ensure that information was provided to people in a format they understood.

The provider monitored the quality of people's care, but some of the issues that had been identified during our inspection had not been identified by them prior to our inspection. People told us there had been a decline in the quality of the service and care workers told us the registered manager did not always engage with them. The registered manager understood his regulatory responsibilities, but notifications of significant events had not always been reported to the CQC as required.

The provider had risk management guidelines in place for areas of risk relating to people's health and safety. Medicines were managed safely and the provider delivered care in a clean and hygienic way. Care was not always delivered in line with current legislation and standards as the provider was not always meeting the requirements of the Mental Capacity Act 2005 or ensuring that lessons were learned from accidents and incidents. Staff were given appropriate support to carry out their roles. People's nutritional needs were met and they worked effectively with multi- disciplinary professionals. 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. The provider met people's cultural and religious needs. People's privacy and dignity was respected. The provider delivered end of life care in accordance with people's needs and preferences. The provider sought feedback from people, their relatives and staff.

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 23 January 2017).

Why we inspected

inspection The first three days of our inspection were planned, based on the previous rating. We extended the inspection by a further day due to receiving concerns from the local authority.

Enforcement

We have identified six breaches in relation to safe care and treatment, person- centred care, consent, premises and equipment, good governance and a breach of the requirement to send notifications. Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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.

Nazareth House - Hammersmith

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 one inspector, an inspection manager, an Expert by Experience and a specialist advisor who was a nurse specialising in the care of older people. 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
Nazareth 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 at the beginning of our inspection. Registered managers similar to providers are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager left the service shortly after the third day of our inspection and we were provided with ongoing support by the regional manager for the provider as well as a new manager who had been appointed.

Notice of inspection

This inspection was unannounced on the first day of our inspection, but we told the provider we would be returning on the subsequent days.

What we did before inspection
We reviewed information we had received about the service since the last inspection as well as the last inspection report. 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 took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service and 14 relatives about their experience of the care provided. We spoke with 21 members of staff including the registered manager, the deputy manager, the regional manager, the newly appointed manager of the service, the Chief Executive Officer for the provider, an activities coordinator, the deputy chef, four nurses and four care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at twelve 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 reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with five professionals who regularly visit the service and liaised with the local authority about the information they found as a result of visits they had undertaken.

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

Learning lessons when things go wrong

● The provider did not keep appropriate records to demonstrate lessons were being learned when things went wrong. We reviewed the provider's accident and incident records and found accurate records were kept when accidents took place along with the actions taken as a result. We read examples of injuries that had occurred as a result of accidents and found nurses had carried out appropriate checks, contacted their GP, referred the person to hospital or called an ambulance as needed. However, actions taken to mitigate future risks following accidents were not recorded and this information was not used to update people's risk assessments.

● The registered manager and regional manager agreed this was an issue with their electronic recording system. They explained they were already in the process of developing a means of appropriately recording this information so lessons could be fully learned. When we spoke with care workers about the risks associated with people's health and safety as a result of accidents, they demonstrated an awareness of incidents that had occurred and the ongoing risks that arose as a result.

Although we found no evidence that people were at risk, the lack of appropriate recording of lessons learned created a risk that some staff would not have full knowledge of risks that arose to people's health and safety This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

● The provider had appropriate systems in place to safeguard people from abuse. People and their relatives told us they felt safe using the service. One person told us "I know I am safer here than being at home because I could not manage by myself." However, despite this comment, the local authority expressed concerns about the risk of people experiencing different types of abuse due to care workers not having appropriate knowledge of safeguarding matters. They are working with the provider to secure improvements in accordance with an agreed action plan.

● We returned on the fourth day of our inspection partly due to these concerns and found care workers understood their responsibilities to safeguard people from abuse. They gave us examples of different signs of abuse and knew what they were supposed to do to prevent this from happening. One care worker told us "You have to report any concerns and the manager will do an investigation and report this to the local authority." Care workers had received safeguarding training in the last year and they told us they found this useful to their understanding of this area.

● During our inspection, we found the provider had a clear safeguarding policy and procedure in place. We have had continued discussions with the provider and have found they are working with the local authority

to secure improvements.

Staffing and recruitment

● The provider did not always ensure enough staff were appropriately deployed to meet people's needs. During the first three days of our inspection both care staff and relatives expressed concerns about the number of staff that were deployed to meet people's needs. People expressed concerns about the numbers of agency staff in use, particularly during the night shift. One relative told us "there are not enough staff for the number of residents."

● The registered manager told us there was an issue with staff deployment and not with staffing numbers. From our checks of staffing numbers and the provider's dependency data, we found the numbers of staff were adequate to meet people's needs. The registered manager told us there were some times of the day that were significantly busier than others and this could create the impression there were not enough staff. He told us he was working with care staff to improve how they were deployed and how they used their time. When we returned on the fourth day of our inspection, we found staffing numbers had increased and care workers reported significant improvements regarding staffing numbers.

● The provider conducted appropriate pre- employment checks before staff started working at the home. We reviewed twelve staff files and saw evidence of at least two references, a full employment history, criminal record checks and staff member's right to work in the UK.

Assessing risk, safety monitoring and management

● The provider assessed the risks to people's health and safety and had written guidelines in place for staff in how to manage areas of risk. We did not always see specific risk assessments in place, but we saw areas of risk were identified in people's care plans along with advice for care workers in how they were required to mitigate this. For example, we saw care plans relating to people at risk of falls. Their care plans contained written advice for care workers such as ensuring their environments were free of clutter, ensuring they were wearing appropriate footwear and had any mobility aids within reach.

● During our inspection we found the provider had a maintenance team in place who were responsible for managing any issues relating to equipment. Some staff expressed concerns about the availability of slings. Senior staff agreed to look into the matter further. The local authority expressed concerns after our inspection about the age of some of the equipment in use at the service. The provider is working with the local authority to address concerns as part of an action plan.

● We found equipment was checked and where issues were identified, they were first checked by the maintenance team and then escalated to an external engineer if necessary. The local authority expressed concerns about the age of some of the equipment in use and these were replaced before the fourth day of our inspection. People's environments were checked daily to ensure the premises were safe and the maintenance team checked the safety of lights, fittings and other aspects to do with the fabric of the building.

Using medicines safely

● The provider ensured the safe management of people's medicines. The home received people's medicines every 28 days and these were placed within weekly packs within dedicated medicines trolleys that were used per unit. Administration of medicines was accurately recorded within Medicines Administration Record charts (MARs). Clear protocols were in place for 'as required' or PRN medicines as well as medicines that were required to be administered covertly. We observed nurses administering medicines to people and found their practice to be appropriate. They observed people taking their medicines and made an immediate record.

● Medicines were stored properly onsite. There was a dedicated clinic room for the storage of medicines trolleys. Refrigerated medicines were stored properly and fridges were checked daily with temperatures

recorded. Controlled drugs were stored in accordance with requirements and a controlled drugs book was used and signed by two members of staff when these medicines were administered.

● Unused medicines were sent offsite for disposal. Records were kept of medicines that had been sent back to the pharmacy for this purpose.

● There was oversight from a pharmacist to ensure medicines were managed safely. The pharmacist conducted an audit of medicines annually. We met the pharmacist on the first day of our inspection and he commented positively about the provider's practice, stating they would work together to identify and rectify any areas of improvement. The provider conducted weekly and monthly medicines audits. We found these did not identify any areas of concern.

Preventing and controlling infection

● The provider acted reasonably to keep the environment clean and free from infection. During our inspection we found the environment to be clean and tidy, however, on the fourth day of our inspection we did find some fabric furnishings which may have compromised effective infection control due to their age. The provider agreed to replace these. There was a sluice room in place for the hygienic disposal of waste items and cleaners were employed to keep the home clean throughout the day.

● We observed the home environment was clean and free of clutter. We observed care workers using personal protective equipment such as gloves and aprons throughout our inspection.

● Care workers had a good understanding of the importance of maintaining good hygiene levels and gave us examples of how they did so. One care worker told us "We keep washing our hands and changing our gloves. We have all the supplies we need to keep things clean."

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 interest.

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.

● The provider was not always working within the principles of the MCA because within our sampling, we identified two examples of mental capacity assessments not being in place when needed. Where people lacked capacity to make particular decisions, their capacity was usually assessed and best interest decisions were made. However, on the fourth day of our inspection we identified two people who were being given their medicines covertly, but did not have specific mental capacity assessments in place for this. The provider agreed to look into this as soon as possible.
Although we found no evidence that that people's liberty was being restricted, the lack of mental capacity assessments for two people created the risk of care being provided against people's wishes. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care workers understood whether or not people had capacity to consent to their care needs and told us they sought people's consent before providing them with care. One care worker told us "I always ask for people's permission before I give them any sort of care- like personal care. If they don't want any help, that's fine. I do what people say."

Supporting people to live healthier lives, access healthcare services and support
● The provider did not always effectively support people with their health needs. People's records contained information about their health conditions and medical histories, however, there was insufficient, recorded information in relation to their mental health needs that care workers could need to deliver appropriate

person- centred care.
● We read one person's care plan and this stated they had depression. Their care plan stated they were currently stable within the home, but there was no information about the effect this condition could have on their on their daily living and whether there were any triggers that could exacerbate their condition. Another person's care file stated they had schizophrenia. The registered manager confirmed that since they came into the home they had been asymptomatic. However, there was no recorded information about the history of this person's condition or if there were any triggers to this that could effect their wellbeing. This meant that if this person was to become unwell in the future, there was no written guidance available for care workers to refer to.

Adapting service, design, decoration to meet people's needs
● The home was not appropriately adapted in term of its design and decoration to meet people's needs. The home was sparsely decorated, with some areas in a poor state of decoration. Although there was step-free access to the building and a lift for people to move easily between floors the building was difficult to navigate and there were no visible aids or reference points to assist people with dementia to orientate themselves.
● The provider agreed the home was in need of refurbishment and redecoration and told us plans were in place for this to take place within the next year.

Although we found no evidence that that people's wellbeing had been adversely affected, the poor condition of the home created a risk to people's wellbeing. This was a breach of regulation 15 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
● The provider assessed people's needs and choices before they moved into the home and used these to formulate their care plans. People's care plans covered a range of different areas of their physical health needs. However, we found information relating to people's mental health needs was sometimes lacking in detail.
● People's care was not always delivered in line with current legislation, standards and guidance as the provider had not always met the requirements of the MCA and was not taking appropriate action to learn from accidents and incidents. We saw the provider used nationally recognised tools in other areas, such as for assessing people's risk of developing pressure sores or their risk of malnutrition. Where needed, the provider sought advice from fully trained and registered healthcare professionals who provided up to date guidance.
● The provider had policies and procedures in place which reflected current legislation and were updated annually or sooner where needed. For example, we saw the provider's safeguarding and infection control policies reflected up to date legislation.

Staff support: induction, training, skills and experience
● Staff received appropriate support to conduct their roles. Care workers told us they received an initial induction, regular training, supervisions and an appraisal of their work and records confirmed this. New care workers received an induction which followed the principles of the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
● Care staff received yearly training in numerous areas which included first aid, moving and handling and infection control among other subjects. Supervisions took place approximately every three- four months and appraisals took place on an annual basis. Care workers told us they felt well supported in their roles and found supervision sessions particularly useful. One care worker told us supervisions "are very useful. We are

all human beings and we make mistakes. This is a chance to get some real feedback about where we need to improve."

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

● People were appropriately supported with their nutritional needs. People gave good feedback about the food provided. We spoke with the chef on the third day of our inspection and they had a clear understanding about people's needs and how they supported people with these.

● We sampled the food on the first day of our inspection and found the food to be appetising, of a good portion and served at the right temperature.

● Care records contained information about whether people required particular support or whether they were on a special diet or had allergies and kitchen staff were aware of people's needs. People's weight was monitored on a monthly basis where needed and people who were at particular risk of dehydration or malnutrition had their food and fluid intake recorded. People's risk of malnutrition or dehydration was also monitored by the registered manager monthly along with the plans that were in place for dealing with this.

Staff working with other agencies to provide consistent, effective, timely care

● The provider worked effectively with other professionals to provide people with care. Multi- disciplinary professionals gave good feedback about their working relationship with the provider. One health care professional told us "I have always been extremely impressed with the care and responsiveness of staff." People's care records contained details about other treatment they were receiving or other professionals that were providing them with care.

● People had access to professionals such as dentists, occupational therapists, dietitians and optical support when needed. The provider also had weekly GP visits to the home to ensure people's needs were responded to.

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. 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

- People and their relatives made some positive comments about individual care workers, but also stated they did not have enough time to meet more than people's basic care needs. One relative said care workers on the day shift were "very caring", however, another relative told us "My [family member's] basic care needs are being met but quite frankly that is all." The relative told us their family member was being kept safe, but their wellbeing was being compromised due to care staff not having enough time to meet more than their basic needs. On the final day of our inspection we found staffing numbers had increased, but enough time had not passed for us to see the impact of this on the treatment of people using the service.
- The provider had not consistently ensured that people were well- treated and supported because they had not always ensured people rights were respected as their capacity to make decisions were not always assessed when needed. Furthermore, risks to people's health and welfare were not appropriately addressed as the provider did not have effective processes in place to deal with incidents and accidents.
- Care workers understood people's preferences in relation to their care and gave us examples of these. This included people's preferences in relation to their food, how they took hot drinks as well as other matters. People's care plans contained some information about their life histories. This included details such as whether they were married, their previous occupations as well as the people important to them.
- There was information recorded about people's religious and cultural needs. The majority of people using the service were from the Catholic faith, as Nazareth House is a Catholic care home. There were some people using the service from other denominations of the Christian faith, but at the time of our inspection nobody using the service practised any other religion. We spoke with the deputy manager and they told us, people from other faiths were welcomed and they had links with various religious leaders. People's care records contained details of people's preferences in relation to how they practised their religion, including whether they attended Mass which was held in the in- house chapel.

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

- People were supported to be involved and make decisions about their care. We observed care workers speaking to people at an appropriate pace and gave them the opportunity to respond before they provided them with support.
- People's relatives told us they were involved in making decisions about their care needs and care plans included information about people's preferences which were sought directly from people The provider had links with advocacy agencies, if needed.

Respecting and promoting people's privacy, dignity and independence

● Care workers appreciated the importance of protecting people's privacy and dignity and gave us examples of how they did so. One care worker told us "Personal care is an important time to build trust. You respect people and help people with what they want. You have to be gentle too."

● From our observations of the care provided, we found care staff to be caring and kind in their approach to people. We observed care workers knocking on people's doors before entering and speaking to people kindly.

● Care staff understood how to support people to be more independent and gave us examples of how they did so. One care worker told us "We encourage people to do things for themselves." People's care plans contained information about what people could do for themselves as well as what support they needed.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- The provider did not always ensure activities were available that met people's needs. We reviewed the activities timetable and observed the activities that were taking place during our inspection and found there was insufficient stimulation for people with dementia needs.
- The provider employed two activities coordinators who took responsibility for the provision of activities during the week and care workers were required to deliver the programme during the weekend. The types of activities conducted included exercise sessions, having tea or coffee in the garden and pet therapy. There was a reminiscence room with a magic table for people with dementia, but relatives told us this room was rarely used and due to insufficient staff, there were few activities taking place on the weekend.
- Staff reported they were sometimes too busy to be able to take people to some of the activities on offer. The registered manager acknowledged that whilst the service tried to provide activities that had universal appeal, they could do more to tailor activities to the needs of people using the service, including those people with dementia.
- We were not assured that people were being protected from the risk of social isolation. Staff told us people who could not leave their rooms were visited by care staff and received music therapy. However, the provider was not monitoring people's involvement with activities or whether they enjoyed them.

Although we found no evidence that people's wellbeing had been affected, the lack of activities for people with dementia as well as the lack of recording in relation to people's involvement in activities created a risk to people's wellbeing. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- People's relatives told us whilst their complaints were responded to appropriately, the provider did not take appropriate action to address their concerns. One relative told us they were listened to but they "continue to have issues with activities and carers" and another relative told us "management fob us off."
- We reviewed the provider's complaints records and found they contained clear and prompt responses to complaints received along with actions they would take as a response. We saw formal complaints investigation reports contained details of lessons learned as a result.
- The provider had a clear complaints policy and procedure which stipulated the timeframes for responses as well as the procedure to be followed in managing complaints.

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

● People's care plans contained some information about people's particular needs, but these were not being followed. For example, we saw recorded information within care plans about people's bedtime routines and their personal care routines. However, people's relatives told us, although they were asked questions about their relative's preferences in relation to their care, these were not being met in practise. One relative said, "a lot of the staff do not follow care plans."

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.
● The provider did not ensure people were given information in a format they understood as information was not provided to people in other formats such as easy read. We did not identify any person who required information in another format, but the potential for information to be provided in other formats had not been considered. The regional manager assured us this would be looked into as soon as possible.
● People's care records contained communication care plans which specified how people communicated their needs. For example, we saw one person's care plan stated that staff were required to communicate with them slowly and ensure they understood them before expecting an answer.

End of life care and support
● The provider took action to provide people with appropriate end of life care and support. People in receipt of end of life care had care plans in place that stipulated their specific spiritual needs, including the type of prayers they would like to be said and who they wanted to deliver this as well as details such as to whether or not people required resuscitation in the event of a cardiac arrest.
● The provider had clear policies and procedures in place relating to people's end of life care needs and worked with external professionals such as hospices and people's GP's to deliver care that met their needs.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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 his responsibility to report incidents to relevant organisations, but this had not always occurred. Notifications of significant events were not always sent to the CQC as required in line with the provider's responsibilities. We identified five Deprivation of Liberty (DoLS) authorisations that had not been reported to the CQC in line with the provider's responsibilities.
- The registered manager acknowledged that one of these instances was an oversight and he agreed to send this to the CQC as soon as possible, but he was not aware of the other four instances as he told us these occurred prior to his appointment.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. CQC is considering what further action they need to take against the provider for a failure to send notifications in a timely manner.

Continuous learning and improving care

- Systems of audit were in place but had not always identified the issues we found. The provider monitored the quality of people's care through conducting full annual reviews of people's care needs, monthly care plan reviews, infection control and medicines audits among others. The registered manager was already aware of the issues relating to the design and décor of the building as well as issues relating to staff deployment. However, issues in relation to people's mental health needs as well as the lack of activities for people with dementia were not identified before our inspection.
- We found the manager who had been appointed prior to the fourth day of our inspection was working with the local authority to help make improvements.

Although we did not find evidence to demonstrate that people had been harmed, the lack of provider's lack of awareness in relation to some of the issues created a risk to the quality of care being provided. This was a breach of regulation 17 of the Health and Social Care Act 2008,(Regulated Activities) Regulations 2014.

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

- The culture of the service was not always positive and achieving good outcomes for people. People's relatives told us there had been a decline in the quality of care in recent months and told us only their

relative's basic needs were being met.
● Care workers gave good feedback about the management of the service but also told us the registered manager could be more engaging with them. One care worker told us "He should come and talk to us more- we would feel more valued if we heard from him more. But he is good."
● Since our inspection, we were informed that there had been changes made to the management of the service and the provider was in the process of hiring a new registered manager to run the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The newly appointed manager had a good understanding about the regulatory requirements in managing the service. He was clear about some of the issues and associated challenges with the service and recognised the need to quickly improve areas of concern that had been identified during our inspection.
● Care workers had a good understanding of their responsibilities. They gave us examples of some of the requirements of their roles and told us their responsibilities were made clear to them before they started work. We read care workers job descriptions and found their understanding tallied with these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider sought people's views and their relative's views through meetings that took place once every two months. We reviewed the minutes from the previous meeting and saw various topics were discussed and people's relatives were given reminders about various issues.
● Care workers told us they were able to give their feedback at any point as their managers were accessible. They also stated they used their supervision sessions as an opportunity to have in- depth discussions about any issues they were having. One care worker told us "The managers have an open- door policy so you can discuss anything you want at any time."

Working in partnership with others
● The provider worked with multi- disciplinary professionals to provide people with the care they needed. Professionals made positive comments about their working relationship with the provider.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that people's care met their needs. Regulation 9 (1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always ensure compliance with the Mental Capacity Act 2005. Regulation 11 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of service users of receiving care and do all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not always ensure premises were suitable for the purpose for which they were being used and properly maintained.

	Regulation 15 (1) (c) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (2) (a).