Hawksyard Priory Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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: Hawksyard Priory is a residential care home providing personal and nursing care for up to 105 people. There were 61 people, some of whom were living with dementia, living at the location at the time of the inspection.

People's experience of using this service:
People did not consistently receive safe care. Peoples needs were not effectively planned for, risk assessments were not followed and medicines were not managed safely.

The systems in place to monitor the quality of care were not effective and actions were not driving improvements. This was a sixth time the service had been inspected and had failed to achieve a good rating; people had been exposed to poor care for too long.
Staff were not consistently trained and able to support people's needs. People were not consistently receiving effective support. People were not always supported by caring and responsive staff.

People felt safe and their privacy and dignity was protected. People could choose for themselves. People had their views sought about the care they received. There were sufficient safely recruited staff.

The service met the characteristics of Inadequate in most areas and was rated Inadequate overall.

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

Rating at last inspection: At the last inspection the service was rated Requires Improvement (report published 2 October 2018).

Why we inspected: This inspection was brought forward due to information shared with us which meant people may be at risk.

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

Follow up: The overall rating for the service is inadequate and the service will be placed in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to

urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. We will continue to monitor intelligence we receive about the service until we return to visit.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not 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**

Hawksyard Priory Nursing 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 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by three inspectors and a nurse who provided specialist nursing care knowledge.

Service and service type:
Hawksyard Priory Nursing 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:
This inspection was unannounced.

What we did:
Before the inspection visit, we checked the information we held about the service. We reviewed other information we held about the service, such as notifications. A notification tells us information about important events that by law the provider is required to inform us about. For example; safeguarding concerns, serious injuries and deaths that had occurred at the service. We also considered information we

had received from other sources including the public and commissioners of the service. We used this information to help us plan our inspection.

During the inspection we spoke with four people who used the service and six relatives. We did this to gain people's views about the care and to check that standards of care were being met. We observed care to help us understand the experience of people who could not talk with us. We spoke with the provider who was also the registered manager, the acting manager, a director and a consultant working with the home. We also spoke with four nurses, two nurse assistants, three senior care staff, four health care assistants, three agency care staff and the cook.

We looked at the care records of 12 people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff recruitment files, training records, incident reports, medicines administration records and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management:
• At our last inspection we found the provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment. This was a breach of regulations. At this inspection we found the provider had failed to take sufficient action in this area and people continued to be at risk.
• One person required regular checks on their blood glucose levels. The plan did not reference what a safe range for the person would be or what actions to take. This meant the person may not receive the treatment they needed and were placed at risk of harm.
• One person required suction to help them with their breathing. There was no detailed guidance for staff on what to look for and what actions to take. The nurse was unable to describe how they would support the person. This meant the person may not receive the treatment required and were placed at risk of harm.
• We could not be assured equipment required for monitoring people's health was clean and working safely. There were no records in place for maintenance of blood sugar and blood pressure machines. A nurse confirmed they were unaware of a system to check the equipment.
• People with risks associated to their care were not monitored effectively. We found significant gaps in people's fluid charts and no checks were done daily to check if people had received sufficient fluid intake. This meant peoples were left at risk of dehydration.
• People with risks to their skin integrity were not being monitored. Where people required repositioning at set intervals there were no checks in place to confirm this had been carried out. We found significant periods of time where records showed people had not been repositioned.

Using medicines safely:
• At the last inspection there were serious concerns about the safe storage of medicines and this was a breach of regulations. At this inspection we found the provider had failed to take sufficient action and people remained at risk of harm.
• The medicines policy was not followed by staff. Nurses were observed preparing medicines and other staff then administered whilst nurses signed the record. The records should be completed by the person administering the medicines in line with current guidance. The registered manger was aware of this practice but had not taken any action.
• We also observed a supplement was left unattended and a person picked this up and was asked to put it down by an inspector.
• Medicines were not consistently stored safely. We found some prescribed medicines used to thicken food were being stored in unlocked areas, despite staff confirming for us they knew this practice was not safe. This left people exposed to a serious risk of harm if they ingested the medicine.
• We saw oxygen which was not stored correctly. The registered manager told us they would complete a check and remove the medicines or provide locked storage facilities.

• We found medicines which had not got opening and discard by dates recorded. This meant people were at risk of receiving medicines which were not effective.
• Medicine stock checks were not effective. We found differences between the stock in the electronic system and the actual medicine available. This meant people were at risk of not having their medicines continually available.
• Medicine administration guidance was not accurate. One person was prescribed 'as required' medicines to be administered if they experienced a seizure. The medicine administration records did not inform staff of what to look for or when to administer the medicine. This meant the person may not receive their medicine as prescribed.

• This meant there was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Supporting people to stay safe from harm and abuse, systems and processes:
• At our last inspection we found there had been a delay in reporting incidents to the local safeguarding team. At this inspection we found issues were reported promptly.
• People felt safe living at the service. One person told us, "I am happy with everything here". A relative told us, "It is safe the staff are great."
• Staff could describe different types of abuse and how they would recognise them. One staff member said, "I would speak to a nurse or senior, go to the registered manager. I have not had to report any concerns, I hope they would deal with it. If not, I would go to the local authority or CQC."
• One relative raised concerns with us during the inspection about an incident which they had not raised with the registered manager. We spoke to the registered manager about this and they took immediate action to investigate and report the concerns.
• The registered manager could tell us how previous incidents had been investigated. Where concerns had been raised, these had been investigated and reported to the local safeguarding authority as required.

Staffing levels:
• At the last inspection improvements were needed to ensure sufficient staff and nurses were available to support people at the times of their choosing. At this inspection we found improvements had been made and there were sufficient staff.
• People and relatives had mixed views about if there were sufficient staff available. One person said, "I have no concerns about the staff." A relative told us, "Staff are great, I know they need their break but there's nobody about when you want them. They are busy with other things. It's a reasonable wait though." Another relative added, "The staff come really quickly when [person's name] calls them using the buzzer."
• Staff confirmed there were enough staff to meet people's needs and staffing had greatly improved since the last inspection.
• We saw there were sufficient staff to keep people safe. We saw people did not wait for their needs to be met, staff were available and accessible to people throughout the inspection.
• Where people needed one to one support this was provided. However, the home was still using agency staff to cover some vacancies, we saw some agency staff were unaware of people's needs. For example, one person was receiving one to one support from an agency staff member and they had not supported the person before. They were given a hand held device to read about the persons needs. The registered manager told us recruitment was ongoing.
• Staff were recruited safely. Staff told us checks were carried out to ensure they were suitable to work with people and the records we looked at confirmed this.

Preventing and controlling infection:
• At the last inspection we identified concerns with infection control procedures not being followed and concerns over the cleanliness of some areas of the home and management of laundry. At this inspection we

found the provider had made improvements.
• The home was found to be clean and we saw there were cleaning schedules in place and checks were carried out to maintain the home.
• There was guidance in place for staff on how to minimise the risk of cross infection.
• Staff confirmed they had received training in how to minimise the risk of cross infection and were observed following the procedures and using protective clothing.

Learning lessons when things go wrong:
• There was a system in place to learn from incidents and accidents. The registered manager told us when incidents occurred they were reviewed and action taken to minimise the risk of reoccurrence.
• We saw incidents were monitored individually by the registered manager and actions were taken following the review to ensure any learning and changes to people's care was in place.
• We saw analysis of accidents and incidents was completed by the electronic system which identified if there were any trends which needed to be considered.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• At our last inspection we found improvements were needed to the information which was stored in the electronic system as this was not fully completed, at this inspection we found improvements had been made, however more were needed.
• People's needs were assessed; however, plans were not consistently put in place to meet them.
• For example, one person was known to have seizures, there was no specific plan in place which guided staff on how to support the person, including the potential use of medicines.
• We could confirm the person had not had a seizure during their time at the home however nurses were unclear in their description of how they would support the person if this occurred. The registered manger confirmed this had been updated on day two of the inspection.
• There was guidance from other professionals included in the plans for people where needed. For example, information from health professionals involved in people's skin integrity plans.
• Plans were reviewed monthly and any changes to people's needs were considered, however these were not always accurately completed. For example, one person had a fall and this was not referenced in the review of the persons mobility plan.
• Nurses and staff had mixed views about the system. Some staff told us the recording system sometimes didn't work as it relied on a Wi-Fi connection and did not capture peoples care delivery. Nurses and staff said sometimes it was hard to locate the information they needed in the care plans.
• The system for assessment and care planning was electronic and used a mixture of text choice responses and free text for nurses to record the care people needed. The detail in the plans varied and some needs did not have a specific plan in place to guide staff.

Staff skills, knowledge and experience:
• The registered manager told us staff had access to a range of different training some of which was external and some was delivered by the registered manager.
• However, staff were not always using their skills to provide effective care. For example, staff were not completing care plans fully, medicines procedures were not followed correctly, and we saw manual handling which was not in line with good practice.
• Staff told us they had not received any specialist input and training for supporting people with dementia. We saw staff did not engage people effectively and people were left for long periods of time without activity or intervention from staff.
• Staff and nurses told us they felt supported in their role and could speak with the registered manager about things if needed. However, they commented that they did not always have regular opportunities to discuss their role. There was no evidence that competency checks were in place for staff.

• Despite this, people and their relatives told us they thought staff had the required skills and knowledge. One person said, "I have no concerns with the staff they seem very well informed and trained."

Supporting people to eat and drink enough with choice in a balanced diet:
• People had their needs assessed and plans put in place to meet them for food and fluid intake. However, there were considerable gaps in the records for fluid monitoring. We confirmed with staff and from records, people were receiving the support they needed to keep safe, and this was a recording issue.
• One person was at risk of choking. We saw there was a risk assessment and plan in place. Guidance had been sought from the Speech and Language Therapy Team (SALT) this was included in the plan and we observed staff following this guidance whilst people were being supported.
• People could choose their meals and were happy with the food. One person told us, "The food is great, we have a choice and I choose to have my meals in my room at weekends and go to the dining room during the week."
• The cook told us people had a choice of meals and there were always alternatives available. The cook said, "We don't puree the food together. We like people to have colourful plates."

Staff providing consistent, effective, timely care:
• At our last inspection, people received support from agency staff who did not understand their needs and could not access the care planning system. At this inspection we found this had improved but further improvements were needed.
• There were written handover documents used to share information with staff coming on to a shift.
• However, there were issues with records not being completed for care that had been delivered. This meant staff may not be fully aware of the support people had received.
• Staff told us that sometimes it was difficult to determine responsibilities during a shift. We found there was little leadership on the floor and it was unclear who was responsible for ensuring people had received their care and support.

Adapting service, design, decoration to meet people's needs:
• At the last inspection we recommended the provider seek advice on adapting the care home environment to suit the needs of people living with dementia.
• At this inspection we found some improvements had been made but more were needed.
• For example, there had been a pub area, café and secret garden area created designed to stimulate people. However, during the inspection, we found people did not access these areas and staff were not seen encouraging them to spend time there.
• Some doors had been painted with different colours, whilst others were not yet completed, although this work was planned.
• We found signage had improved, but there were no pictures included with the signs which would support people living with dementia to understand where they were.
• There were no items available to provide stimulation from touch, sight or smell for people living with dementia.

Ensuring consent to care and treatment in line with law and guidance:
• At the last inspection we found people had not consistently had their capacity assessed and best interest's decisions were not recorded. At this inspection we found improvements had been made, however more were needed.
• The 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 with appropriate legal authority. 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. Where people did not have capacity to make decisions, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
• Staff understood their responsibilities under the MCA and followed the principles of the MCA. Where needed people had a capacity assessment and decisions were taken in their best interests. However, some assessments lacked detail about how people could be supported and the MCA form was not fully completed.
• When a person was being deprived of their liberty, the service had applied for the appropriate authority to do so.

Supporting people to live healthier lives, access healthcare services and support:
• People had access to support with their health and wellbeing. One person told us, "My back was sore, and they got me a specialist mattress, which was done very quickly. "One relative told us, "The staff get the doctor if [person's name] is not very well".
• Records showed people had been referred promptly for specialist health advice including from a tissue viability nurses (TVN), SALT professionals and Doctors.
• Where advice was given we saw this was incorporated into people's care plans and followed by staff. For example, wound plans were updated with advice when a TVN nurse had visited.

Requires Improvement

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported:
• At our last inspection we found improvements were needed to the engagement between people and staff. At this inspection we found improvements had been made, however more were needed.
• Some staff missed opportunities to engage with people. Where people struggled with verbal communication due to living with dementia, we found staff did not always engage with the person and try to communicate. This meant people were often spending time alone without interaction.
• Despite this, people and relatives told us staff were nice and caring in their approach. One person said, "The staff are all lovely here, I have no complaints about them." One relative told us, "The staff come in and have a laugh with [person's name], and they have a joke with us too."
• People personalised their bedrooms and had regular visits from their relatives and friends. One relative told us, "We can visit whenever we like. We have been able to personalise the room, by putting photos up."
• People appeared to be comfortable with the staff. We saw people smiling and laughing with staff during interventions.
• We saw staff were respectful and polite when speaking to people. One staff member was seen encouraging a person to have a drink, they sat by the person, maintained eye contact and the person was engaged with them.
• People had their communication needs assessed and planned for. Staff understood how to communicate effectively with people and were observed following the guidance in people's individual plans.

Supporting people to express their views and be involved in making decisions about their care:
• At the last inspection people were not consistently supported to make choices. At this inspection we found improvements had been made.
• People told us they could make their own decisions and choose for themselves and were supported to maintain their independence. One person told us, "We had a meeting when I first moved in, I told them how I wanted things done and they have stuck to it."
• Staff told us people could make their own choices and decisions and could describe how they supported people. One staff member said, "People can choose everything, when to get up and go to bed, meals, clothing, anything."
• We saw staff offered people a choice. For example, people had a choice of drinks and meals and could choose where to spend their time.

Respecting and promoting people's privacy, dignity and independence:
• At the last inspection people were not always treated with dignity and respect and their privacy was not maintained. At this inspection we found improvements had been made.

• People had their privacy and dignity respected by staff. One relative told us, "The staff always ask me to leave the room when supporting [person's name] which I think is nice as this gives them some privacy." Another relative said, "The staff are lovely, they seem kind and always ask permission, they show patience."
• Staff were observed knocking doors and ensuring people had their privacy maintained. Staff were respectful in how they spoke with people and about them.
• Staff shared examples of how they supported people to maintain their dignity and respect their privacy; such as closing curtains and knocking doors.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• At our last inspection people were not consistently supported with access to activities. At this inspection we found this had improved, but more improvements were needed to ensure everyone at the home could be supported with social interaction.
• Most people told us they spent their time alone in their room. One person said, "I choose to spend time in my room." A relative told us, "[Person's name] gets all the care they need but perhaps they could do with a bit more attention during the day."
• We saw staff doing activities with small groups of people. For example, three people were singing with staff in a lounge area to a music DVD on the television. The people were engaged in the activity and were smiling and enjoying themselves. On another occasion we saw a small group playing a game with a ball. We also saw a couple of people out for a walk around the grounds.
• However, most people told us they spent most of their time alone in their rooms. The staff did not have time to spend with people individually. This meant most people were spending large parts of the day isolated.
• On the top floor most people were sat in the lounge without activity. There was a continuous staff presence in the lounge areas however we did not see staff engage people in conversation or activity. Other people continuously walked around the corridors, staff did not attempt to engage these individuals in activity.
• Peoples protected characteristics were considered and recorded in assessments and care plans. Staff could give examples of how this information helped to guide them when supporting people.
• Staff understood people's needs and preferences, however care plans did not consistently include this information which meant there was a risk of inconsistent support.

Improving care quality in response to complaints or concerns:
• People felt they could raise any concerns or complaints with staff and the registered manager. One relative told us, "I feel able to raise concerns with the registered manager and with any of the staff."
• There had been only one complaint since the last inspection and this had been investigated and a response given. Actions had been taken to prevent the situation from occurring again.

End of life care and support:
• At the time of the inspection no-one was receiving end of life care.
• People's future wishes were considered with them and relatives and where appropriate the registered manger told us they would document this in people's care plans. We saw there were some aspects of people's future wishes documented in people's care plans.

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• The provider has consistently failed to implement systems to monitor, assess and improve the quality of care provided to people in the home.
• At our previous five inspections carried out in November 2014, July 2015, May 2016, April 2017 and August 2018 we found that improvements were required in aspects of people's care and that regulations had been breached. This meant people had been exposed to poor care for an unacceptable amount of time.
• At our last inspection the provider was in breach of regulations and were issued with a requirement notice and an action plan was put in place to address our concerns. A provider meeting was held jointly with the local authority to gain assurances about how the provider would bring about improvements.
• At this inspection we found the provider had not fully implemented the action plan to bring about sustainable improvements in the quality of care that people received.
• The provider had put in place an audit system for risk assessments and care plans following our last inspection. However, the audit process had failed to identify the concerns we found which meant people were left at potential risk of harm. This meant the provider could not be assured risks to people were being mitigated and their needs were met.
• The provider systems had failed to check the accuracy of assessments and care plans. For example, one person who was at risk due to seizures had no documented guidance in their care plan for staff to follow, and this had not been identified.
• The providers systems had failed to identify the lack of detail in care plans to keep people safe from the risk of harm. One person required the use of suction, there was no documented guidance for staff. One person required regular checks on their blood glucose levels, however there was no safe range documented on the persons care plan.
• Systems had also failed to identify the lack of detail in peoples individual MCA assessments and the lack of person centred information available to staff about people's preferences.
• There was no system in place to check people had received the care they needed. This meant the provider could not be assured people were having their needs met.
• We found there were significant gaps in people's records. Food and fluid charts had multiple gaps, as did repositioning charts. This meant we could not be assured people had received the care they needed to keep them safe, and that the provider did not have effective systems in place to check this.
• The system to monitor medicines was not effective. Despite an audit process being in place medicines stock records were not accurate, medicines were not being stored in line with the policy and staff were not following the policy for safe administration and recording. This meant the provider did not have an effective

system in place to ensure that all medicines were managed safely.
• The provider had failed to ensure an accurate record of staff training was in place despite a system being in place to monitor the training staff had received. We found there were gaps in the training records which showed staff training was overdue. The registered manger told us staff had been trained but the records had not been updated.
• The provider did not have effective systems in place to maintain oversight of staff. There was no system to check nurses and staff followed procedures, care plans and utilised their training correctly.
• We saw nurses not following the medicines procedures in place for safe medicine administration. The registered manager did not have a system in place to identify these issues.
• There were inconsistencies in systems for checking, cleaning and maintaining medical equipment. There were gaps noted in the checks on a suction machine and no records of checks on other medical equipment such as blood sugar and blood pressure monitoring equipment. This meant the provider could not be assured the equipment was in working order and available to nursing staff.
• We found the provider was aware of their responsibilities for submitting notifications of incidents that had occurred at the service, which is required by law. These may include incidents such as alleged abuse and serious injuries.
• However there had been a significant number of safeguarding concerns raised by the local authority and notifications had not been received.
• The registered manager said this was an oversight due to changes in the management structure and they submitted these retrospectively.
• The evidence above showed that the systems in place to monitor and mitigate risk to people were ineffective. The provider had not ensured that improvements were identified and sustained at the service.
• This meant there was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff:
• People and relatives were asked for their views about the quality of the service and making suggestions. One relative told us, "There are questionnaires by the door which we can fill in about the service, we have never completed one."
• People and relatives told us they felt able to speak with the registered manager and staff about the service. One relative said, "We do feel involved, they come and speak to us when things change. They do ask us what we think."
• The resident of the day process in place meant each department would check peoples experience on this day. For example, checks were done on their room and equipment and if they were happy with things.
• A cook told us people were asked about meals experience they commented, "We ask if they like the food, the times, the snacks and what food they'd like. We do different foods if people want them, two people like curry so they've had that for example."

Continuous learning and improving care:
• The provider told us they had been subject to review by the commissioners of peoples care and had been proactively acting to address concerns raised through these processes.
• The provider had recognised they were failing to address all the concerns and had taken advice and entered into an arrangement with an external consultancy to offer support.
• The consultant working at the home told us they had been in place for two weeks and were assessing and identifying the issues which required addressing.
• The consultant had begun to develop an action plan to address the lack of governance arrangements in the home.
• The provider confirmed their intention to retain the services of the consultant to establish clear governance arrangements, recruit a new registered manager and have an ongoing monitoring role within the service.

• The registered manager, who was also the registered provider, confirmed their intention to step back from the role of registered manager once a new appointment had been made.

Working in partnership with others:
• The registered manager told us they worked in partnership with other professionals. For example, working with the tissue viability nurse and SALT team to support people effectively.
• Nurses told us they had worked with other agencies to develop specialist roles which focussed on aspects of nursing care. For example, specialist training for supporting people with skin integrity.
• Staff confirmed they had access to a range of different professionals to support with developing effective care planning and records we saw supported this.