Minearch Limited

The Shieling

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Shieling is a care home providing accommodation and personal care for up to 29 adults. There were 29 people living at the service at the time of the inspection. Some of the people lived with dementia and required support with their physical needs.

People's experience of using this service and what we found
People did not receive safe care and treatment. Our observations and findings showed that care practices did not follow safety guidance. People did not always receive their medicines safely to manage their conditions. Safeguarding protocols had not always been followed to report injuries and falls and to ensure oversight from external agencies. Risks to people were assessed however, they had not been timely reviewed. People at risk of repeated falls, dehydration and skin breakdown had not been adequately monitored and supported in line with their care plans. Risks associated with fire were not managed because staff were untrained, and the premises had not been serviced as required. The provider's recruitment practices were unsafe. Infection prevention protocols were not robust to prevent and reduce the spread of infections.

People were not supported by staff who had the right skills and knowledge. Staff did not receive suitable induction and training to meet people's needs. People were not supported to have maximum choice and control of their lives because their capacity to make decisions was not always assessed. People were not adequately supported to ensure they received enough to eat and drink. People told us staff sought their preferences. Staff supported people to have access to health professionals and specialist support. The registered provider did not have robust governance arrangements to promote a person-centred approach and the delivery of safe and high-quality care. There was a lack of audits, monitoring and shortfalls were not identified and resolved in a timely manner. Staff gave mixed responses regarding the culture and management style in the home and there was low morale. There was a lack of robust leadership and oversight on the running of the service and people's experiences of care.

People were not always supported to ensure they received the care that they required and in line with best practice guidance. Care records were not reviewed when people's needs changed to reflect people's current needs, and some had no care plans for their needs. People were not adequately supported towards the end of their life and staff had not received training in end of life care. There were arrangements to maintain regular communication between relatives and staff.

People and their relatives were positive about the service and said staff were kind and caring. However, our findings showed that this was not consistent, and the unsafe use of medicines had a potential impact on people's dignity, respect and human rights. People's property was not always returned after they were deceased.
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 02 April 2020).

Why we inspected
We received concerns in relation to the management of people's needs, the governance and the leadership in the home. A decision was made for us to inspect and examine those risks.

We have found evidence that the registered provider needs to make improvements. Please see the safe, effective and well-led sections of this report. We took immediate action to protect people.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement:
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold register providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe from preventable harm such as medicines management and falls and fire safety risks. We also found concerns regarding safeguarding, responding to changes in people's needs, deploying suitably qualified staff and poor governance at this inspection. Please see the action we have told the registered provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss the future of the home. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the registered provider's registration, we will re-inspect within six months to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the registered provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our well-led findings below.	**Inadequate**

The Shieling

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 registered 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors, a pharmacy inspector and an inspection manager carried out the inspection.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.
At the time of our inspection there was a registered manager in post however they were on leave.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service, including information from the registered provider about important events that had taken place at the service, which they are required to send us. We

sought feedback from the local authority. The registered provider was not asked to complete a registered 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.

During the inspection
We spoke with six people who lived at the home about their experiences of the care provided. We spoke with eight members of staff including the human resources manager, senior care staff on the inspection. We spoke with two relatives. We also spoke to the director who is also the owner of the service. We reviewed a range of records. This included six people's care records, multiple medication records, accident and incident records three staff recruitment records and we looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the owner and the nominated individual to validate evidence found. We met with the local authority and other stakeholders to discuss our findings. We looked at training data and quality assurance records and sought feedback from health and social care professionals.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

● People were not adequately protected from the risk of harm because arrangements for assessing, reviewing and monitoring risks were not robust. Whilst risk assessments had been carried out, measures to reduce the risks were not consistently implemented. One person needed turning every two hours in bed to prevent skin damage, however we found this varied between three and five hours increasing risks of skin damage and deterioration.

● People's nutritional risks were not adequately monitored to prevent malnutrition and unintentional weight loss. Records of nutritional monitoring showed people were not consistently assisted with their drinking where this was required. Records of fluid intake for one person who was a high risk of dehydration had not been completed for seven days. Our observations showed the person had signs of dehydration and had lost a significant amount of weight. We could not be assured they were receiving the support they required.

● People at risk of falls had been assessed however risk assessments and care plans were not reviewed when risk increased. There were no post falls observations carried out when people experienced unwitnessed falls which included head injuries. We saw instances where people had experienced 'bumps to the back of the head and lumps on the head' after unwitnessed falls. However, their care plans stated there had been no increase in risk. Post falls observations are useful to observe injuries that occur after the fall.

● The process for recording accidents and incidents was not robust. There was no accident and incident analysis to identify pattern and trends. We found incidents that had not been recorded. Robust recording of incidents would ensure incidents are appropriately investigated and areas for improvement identified and acted on.

● People were not adequately protected from the risks associated with fire because the provider had not carried out regular fire risk assessments. Staff had not received fire safety training and regular fire evacuation drills had not been carried out. People had personal emergency evacuation plans however staff we spoke to were unsure how to respond in the event of a fire. We could not be assured they would respond appropriately in an emergency.

We found evidence that people had been exposed to harm and systems were either not in place or robust enough to demonstrate safety was effectively 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 (Regulated Activities) Regulations 2014.

Using medicines safely

● People were exposed to risks of harm and poor outcomes because staff did not follow safe and best practice guidance in medicine management and administration. This included, not giving people their

medicines on time, poor records keeping and exposing people to risks of over sedation.
● People were exposed to risks of medicines misuse. Medicines such as lorazepam which have a sedative effect were not used in line with best practice. We found instances where these medicines had been used regularly instead of the prescription direction to use them 'as required'. There was no guidance for staff on when to use these medicines and what actions they needed to take first before using the medicines to support people. This exposed people to risk of chemical restraint or being subdued by medicines.
● Staff who administered medicines had not received up-to- date training or their competence checked. Comments from staff included, "I haven't a clue what medicines I am administering to most people', I do not know what the BNF is." The British National Formulary (BNF) is a United Kingdom pharmaceutical reference book that contains a wide spectrum of information and advice on the use of medicines.
● People did not always receive medicines they were prescribed to relieve their symptoms such as pain and constipation. We observed people expressing they were either in pain or constipated however they had not been offered medicines regardless of the medicines being available. This resulted in avoidable pain and discomfort.

We found evidence that people's welfare had been affected by unsafe medicines administration practices, systems were either not in place or robust enough to support safe medicines management. 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 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The registered manager did not always operate safe recruitment processes. Staff recruitment records we reviewed showed required checks had not been carried out to assess the suitability of staff to work with vulnerable adults.
● Staff recruitment procedures did not demonstrate recruitment checks had been carried out. This included obtaining checks of suitability, checking staff's employment history and carrying out suitable Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider could not be assured if the staff employed were safe to work with vulnerable adults.
● We found three staff members had started working however they had not been interviewed and had no character references or DBS checks.
● On the day of the inspections, there were adequate numbers of staff deployed to support people. We observed people being attended to in a timely manner. However, staff told us they have experienced staff shortages. Comments included, "We have had times of very low staffing, some terrible times four? left two of us only for the last hour, we had only been here a few months." And " The managers finish work early and we are left short-staffed and struggling." We checked records of staff arrangements which confirmed there were times when there was not enough staff to support people.

There was a failure to check that staff employed were of a fit and proper character and to ensure there were adequate numbers of suitably qualified staff. These were breaches of Regulation 18 Staffing) and Regulation 19 Fit and proper persons of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems and processes for safeguarding people from risks of abuse had not been effectively implemented to ensure compliance with regulations and local safeguarding protocols. Staff had not received training in the safeguarding of adults. While some safeguarding incidents had been reported, we found a significant number of repeated falls that had not been reported to the local safeguarding authority in line with local protocols.

● The registered provider did not have robust protocols for facilitating staff to review and learn from incidents and near misses to enable them to improve practices and reduce repeated incidents. This included repeated unwitnessed falls.
● People were at risk of being unnecessarily sedated as a result of the unsafe use of antipsychotic medicines. There was an excessive use of these medicines without evidence why they were needed. This puts people at risk of being over sedated using medicines.
● The registered manager and the provider had not established a system for ensuring lessons were learned following incidents or repeated incidents. They had not shared serious incidents with us as required. The sharing of information would enable robust and transparent investigations to take place.
● The registered manager had not always returned people's property such as jewellery when they were deceased. We found people's property that should have been returned to their family members when they were deceased.

There was a failure to report safeguarding concerns to authorities and protect people from inappropriate treatment. This was a breach of Regulation 13 Safeguarding people from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were not adequately protected from the risk of infections. Systems to protect people, staff and visitors against the risk of infection were not effectively implemented.
● The provider could not demonstrate how they had regularly tested people and staff for COVID-19 infections. In addition, we found staff were not using personal protective equipment (PPE) as recommended including wearing masks under their chins and nose.
● The registered manager and the provider had not carried out regular infection prevention audits and cleaning schedules.
● Staff had not been provided with Infection Prevention Control (IPC) training including the safe use of PPE.

Systems had not been established to prevent and control the risk of infections. This placed people at risk of harm. This was a breach of regulation 12(1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
The home facilitated visits which aligned with the most recent government guidance. Visits from friends and family were actively encouraged to help maintain important relationships and aid people's emotional well-being.

Inadequate

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff were not adequately supported with induction and training into their roles and responsibilities. The registered provider had no system for training staff at the beginning of their employment. They could not demonstrate whether staff had completed training and induction into their roles.
- While training had previously been provided in various areas of care, we found staff had not completed training that the registered provider had deemed mandatory for the role. In addition, staff had not been supported to refresh their training. This included areas such as moving and handling, medicines management, first aid, fire safety and safeguarding. The director told us, "I am confident that all training and mandatory courses have not been undertaken by any staff." Similarly, one staff told us, "I have not completed any training for six years, other than what the manager shows me." The provider had failed to provide staff with supervision and appraisals in line with their own policy and regulations.

There was a failure to ensure that all staff had received appropriate support and training to enable them to carry out their duties. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The directors advised that they had invested in training for the staff team however the training they had arranged had not been rolled out to care staff by the management team at the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- The provider and the registered manager had not always established arrangements to facilitate the delivery of care and treatment in line with legislation, standards and evidence-based guidance. Staff had no access to National Institute for Health and Care Excellence (NICE) guidance in various areas including medicines management and infection prevention.
- Arrangements for supporting people with their oral hygiene were not effective, because people did not always have oral hygiene care plans and staff had not received training in this area.
- People's needs and choices were assessed and reviewed, and requests had been made for external professionals such as dieticians and mental health services to support where required.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection all people living at the home were subject to restrictions under 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 and their staff had not followed the principles of mental capacity and consent. Care records we reviewed and conversations with staff showed that people's mental capacity to make specific decisions had not been assessed and recorded. Staff had not received MCA training.

● There was no evidence to demonstrate that the provider had applied for authorisations to deprive people of their liberties. There were people in the service who were not free to leave the home without supervision and authorisation is required to restrict their liberties for their safety.

There was a failure to seek consent and assess people's mental capacity to make specific decisions. This was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The registered manager and the provider had a system to support people with their diet however the system was not robust. Where a person had food intolerances, their care records did not provide clear guidance to ensure staff understood what the person could or could not eat. Some people had been assessed to be at nutritional risk and needed to be monitored. However, we found their dietary intake had not been recorded to demonstrate they were being monitored. A significant number of the people at risk of poor nutrition had not been reviewed since March 2022. People's weights were not consistently recorded to track people's weight and the risk of unintentional weight loss.

● Food, drink and snacks were available throughout the day guidance from professionals was requested when needed however, it was not always followed including the need to monitor and record people's dietary intake.

Adapting service, design, decoration to meet people's needs

● People's individual needs were met by the adaptation, design and decoration of premises. There were adequate spaces for people to spend their time on their own or to share with others. Access to the building was suitable for people with reduced mobility and wheelchairs.

● Communal areas were provided where people could relax and spend time with others. Corridors were free from clutter, which promoted people's independence.

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; Respecting and promoting people's privacy, dignity and independence

- People's relatives gave mixed responses in relation to the caring nature of staff and whether staff treated people with dignity and respect. While some gave positive feedback and were complimentary about the caring nature of the staff team, some raised concerns about staff attitude and the responses to people's needs. Comments included, "They try to maintain dignity and do their best however it sometimes depends on which staff you talk to." Staff told us at times they had failed to meet people's personal hygiene and continence needs as they are left short staffed in the evenings.
- Care records referred to people in respectful ways. However, people's human rights and ability to make choices had been compromised by the lack of assessment of their decision-making capacity and the overuse of sedative medicines. In addition, staff had not completed training in areas such as person-centred care and dignity and respect.
- We observed people were dressed respectfully and had been supported with their personal hygiene. Staff were observed talking to people in a respectful manner.
- People told us they were consulted about care and decisions for their wellbeing and support they required. However, two relatives told us information regarding hospital admissions was not always shared with them at the time of the event.

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

- The provider had not adequately prompted people's ability to make decisions about their care. Records of care did not demonstrate how people had been supported to make choices about their end of life care. We found no evidence of meetings or surveys with people seeking their views about care.

Requires Improvement

Is the service responsive?

Our findings

Responsive this means we looked for evidence that services met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care

- People did not always receive personalised care in line with their identified needs. Care records did not accurately reflect the care that people received. This included not turning people as required to prevent skin breakdown and failing to accurately monitor people's dietary needs. A person with long term skin conditions did not have a care plan to manage their condition or to provide staff with guidance.
- The registered manager and the provider were not consistently responsive to people's changing needs. Pain relief was not always monitored for one person. Even though they had pain management medicines we found this had not been offered. There was a system for reviewing people's care needs, however, care records had not been reviewed since March 2022. In addition, where people had experienced deterioration such as weight loss, care records had not been updated to reflect the increase in needs.
- Care practices did not always reflect people's interests and choices for example care records for managing people's mental health needs contradicted the way people were given medicines. For example, records showed people were settled and calm and had no concerns however, records showed they were given sedative medicines when there was no reason to do so.
- The provider and the staff had not established robust systems and practices to ensure people and their relatives were supported to share their end of life wishes. People's care records did not include their end of life care preferences or care plans, this included where a person was receiving end of life care.
- Staff had not received training in end of life care. We would expect this to be provided as the home supported people living with terminal and life limiting conditions.

There was a failure to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences. This was a breach of Regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had made referrals to external professionals such as dieticians and district nurses. However, the guidance provided was not robustly followed or reflected in the care practices.

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 registered provider and staff had arrangements and plans for people to take part in activities of their choice in the home. Staff had established ways to support people with activities.
- The registered provider had established a system for supporting people to maintain contact with their families and prevent isolation during the COVID-19 pandemic. We saw care home visits were taking place

during the inspection.

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 registered manager had not assessed people's communication needs as required by the AIS. We found no evidence of communication care plans in the records we reviewed. We could not be assured people could be provided information and reading materials in a format that suited their communications needs.

Improving care quality in response to complaints or concerns
● The registered provider had a complaints procedure that was shared with people's relatives when they started using the service.
● The directors informed us complaints had been received and they had investigated them. However, on the day of the inspection we found the registered manager had not kept records to demonstrate how they had dealt with people's complaints. We therefore could not be assured that complaints had been dealt with in line with regulations and measures had been put in place to address the complaint satisfactorily.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread shortfalls in the governance systems. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The registered manager and the provider did not have a full understanding of their roles. The leadership in the home and decision making did not support the provision of oversight to monitor and anticipate quality performance issues and potential risks to people. We identified shortfalls in the monitoring of the safety and quality of the premises and the care provided. The provider could not demonstrate if equipment such as gas boilers and electrical wiring were serviced and whether they had carried out routine safety checks on bedrails and sensor mats.
- While the home had a registered manager employed, they were not present at the time of the inspection, interim arrangements were in place to manage the service. We found significant concerns regarding the management practices and the provider's oversight on the registered manager and staff.
- The provider had poor systems and processes to monitor quality and to assist in complying with regulations. Their systems had not been robustly implemented to detect and deal with some of the emerging and ongoing risks to prevent deterioration.
- The provider had failed to adequately support staff with skills and knowledge to safely meet the needs of people in the home including medicines management, fire safety, moving and handling and first aid. This had contributed to the deterioration of the standards of care provided and unsafe medicines management practices.
- The provider and the registered manager did not have robust quality assurance systems. There was no evidence of regular quality audits in various areas including medicines, accident and incident, infection prevention and health and safety and staff recruitment and training.
- There were no systems for learning from incidents and near misses. Accident and incidents were recorded however there was no analysis to identify root causes, themes and trends. The registered manager and their staff could not demonstrate whether they had reviewed what could be learned from significant events such as repeated falls to reduce re-occurrences.
- The provider did not have a robust system for maintaining people's records or records linked to the service. We found there was no central record to show who was residing in the home and to show the staff employed and no policies were present in the home.

There had been a failure to assess, monitor and improve the quality, safety and welfare of service users and others who may be at risk. This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the directors showed us evidence of policies that they had invested in before the inspection, however management in the home had not rolled them out or made accessible to care staff to support care delivery.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● We received mixed responses from staff regarding the culture and management's ability to respond to staff suggestions and concerns about people. Staff morale was low and staff stated they did not always feel valued or listened to by management in respect of people's needs and staffing levels. We found no evidence of staff, relatives and resident engagement.

● People's relatives told us they were involved in the planning of their family member's care however this was not evident in the care records we reviewed.

● The registered manager had developed close links and working relationships with a variety of professionals within the local area.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The registered provider did not have systems for promoting person-centred care. Care staff had not received training and support to deliver person-centred care. They did not have a dementia strategy to support the delivery of care to people living with dementia. The systems for supporting staff including inductions, and training were not adequately implemented to support the delivery of safe high-quality care.

● The registered manager had submitted some notifications including death notifications us. However, we found a significant number of repeated falls and serious injuries that had not been notified to us including a fracture.

There had been a failure to notify us of incidents in the home. This was a potential breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009

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 9 HSCA RA Regulations 2014 Person-centred care The provider has failed to ensure care delivered was person-centred and reflected people's needs. Regulation 9 (1)

The enforcement action we took:

We took immediate action and suspended the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to assess people's mental capacity to make specific decisions. Regulation 11(1)

The enforcement action we took:

We took immediate action and suspended the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to risk due to the unsafe medicines practices. People who use services were not protected against the risks associated with unsafe or unsuitable premises because of inadequate environmental checks. Regulation 12(1)

The enforcement action we took:

We took immediate action and suspended the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment People were exposed to the risk of abuse and ill treatment.

The enforcement action we took:

We took immediate action and suspended the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were robust and systems or processes were not established and operated effectively to ensure compliance. Regulation 17 (1) (2)(a)(c) HSCA RA Regulations 2014 Good governance

The enforcement action we took:

We took immediate action and suspended the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure to carryout recruitment checks to support safe recruitment.

The enforcement action we took:

We took immediate action and suspended the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received training, supervision and appraisal to enable them to carryout their roles. The provider had failed to ensure there were adequate numbers of suitably qualified staff.

The enforcement action we took:

We took immediate action and suspended the provider's registration.