

Cole Valley Care Limited

Cole Valley

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

Cole Valley is a residential care home registered to provide personal and nursing care for up to 45 people. At the time of the inspection there were 23 people using the service.

People's experience of using this service and what we found

The provider had developed a range of audits and quality assurance checks to assist with driving improvement within the service. We identified that these systems and processes were not robust and were not kept up to date. They had not ensured the quality and safety of care was sufficiently monitored and that appropriate action was taken to protect people from the ongoing risk of harm.

The registered manager was not aware of changes to the current infection prevention and control (IPC) guidance.

During the inspection we identified concerns with poor IPC standards. This placed people at risk of infection.

Although special dietary needs were shared with staff members by the registered manager, staff were observed to not always follow the correct guidance. People's diverse cultural needs were not always met.

People were supported to have maximum choice and control of their lives. Staff were supporting people in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice although record keeping needed to be improved in relation to the use of the Mental Capacity Act 2005 (MCA).

People were involved in making choices around how they spent their time. Meaningful activities took place which people told us they enjoyed. However, people told us they would like more to do at the weekend. The activity team do not currently work weekends.

People were supported by a staff team who understood how to protect them from abuse. Staff also understood how to protect people from harm such as injury, accident and wounds. People's medicines were managed safely although some improvement was still needed.

People were supported by sufficient numbers of staff to keep them safe. Staff were recruited safely.

People were supported by a staff team who were receiving support from the management.

People were supported by a staff team who were kind and caring and the quality of interactions with people was good. People were treated with dignity.

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

Rating at last inspection and update

The last rating for this service was Requires Improvement at the inspection we carried out on 06 August 2019 (report published 05 September 2019) and there were multiple breaches of regulation.

At this inspection enough improvement had not been made and the provider was still in breach of regulation.

At this inspection the overall rating for this service is 'Inadequate' and the service therefore is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

The service was rated as inadequate at the inspection we completed in February 2019 (report published 09 May 2019) and there were multiple breaches of regulation. The service was rated as inadequate at the previous inspection completed in August 2018 and entered Special Measures. Prior to this the service had been rated as requires improvement at inspections completed in 2017 and 2015.

Why we inspected

This was a responsive five key question inspection based on CQC receiving a Coroner's report which identified concerns, that the provider had not sought to learn the lessons from the circumstances of a person's death and as a consequence there is an ongoing risk to other people living at Cole Valley.

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 monitor the service and we will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Since the last inspection we recognised that the provider had failed to notify CQC of a serious incident, which is a notifiable event. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

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

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

Follow up

If the 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 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.

We will meet with the provider to discuss how they will make changes to ensure they improve their rating and to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not 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?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Cole Valley

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.

Prior to the inspection CQC was notified about a serious incident where someone had died following an accident at the service. The information shared with CQC about the incident indicated potential concerns about how the risk of falls was managed. As a result of these concerns we looked at how the provider was managing risks and protecting people from potential harm caused through accidents and incidents.

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.

We experienced some difficulty in carrying out the inspection due to some staff records not being in place or up to date.

Inspection team

The inspection was completed by three inspectors.

Service and service type

Cole Valley is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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, we informed them of the inspection on arrival at the service.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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

During the inspection

We spoke with seven people who used the service and four relatives about their experience of the care provided. We spoke with eleven members of staff including the registered manager, deputy manager, registered nurses, team leaders, care workers, maintenance officer, activities organiser, administrator and a chef.

After the inspection

We continued to seek clarification from the registered to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who support people using the service.

Is the service safe?

Our findings

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

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

This meant people were not safe and were at risk of avoidable harm.

- Risk to people had not been appropriately managed. Risks in relation to specific health care needs for two people had been identified. There were no risk assessments in place to guide staff to how they should support people. Two people required a specific piece of equipment did not have a risk assessment. This meant staff did not have guidance on how to check the equipment was working effectively or how to maintain good infection prevention and control measures.
- Guidelines were in place to support people who were at risk of choking when eating and drinking. We saw they were not followed through in practice, placing people at risk of harm. For example, one person was given a high-risk food to eat. Staff were not following the guidelines correctly. The person was assessed as needing a specific diet because of the risks to them of choking, but staff failed to do this. We brought this to the immediate attention of the registered manager.
- The fire risk assessment was completed 08 February 2021 which identified improvements were required to the home environment. These had not been actioned. Bedrooms used for storage of inflammable items were left unlocked which increased the risk of fires. There were missing door handles leaving a hole in the door on both occupied and unoccupied rooms. This compromised the effectiveness of the fire doors.
- We found doors to rooms containing chemicals and harmful products were not locked when staff were not present, this could cause serious harm or injury.
- A hoist which was located in a bathroom had not been serviced since 2017. The registered manager told us it was broken and was not used. They told us there had been a sign on the hoist, but this was not there on the day of inspection. This meant this hoist had the potential to be used by staff members, placing people at risk of harm or injury.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The Coroner's report into the death of a person who used the service, identified the need for the provider to reflect on events and incidents which took place to reduce the risk of similar occurrences. The provider had failed to implement reflective practice with the staff members. The registered manager told us this was something she wanted to implement but had not yet done so, due to supporting another service.

Preventing and controlling infection

- We were not assured that the provider was meeting shielding and social distancing rules. We observed two staff members who did not adhere to social distancing rules. The registered manager was also supporting another service. There was no risk assessment taking into consideration the risks associated with moving between locations. The registered manager also told us that they had not completed individual COVID-19 risk assessments for people or staff at increased risk from COVID-19.

- We were not assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. The registered manager was not aware of PPE guidance which had been updated 16 April 2021. This meant staff members did not have access to goggles when supporting people, when at risk of coming into contact with bodily fluids. The registered manager was signposted to the guidance.
- We were not assured that the provider was promoting safe hygiene practices of the premises. There was not a robust cleaning regime in place to include all equipment used to support people. Items of equipment had a build-up of dirt and coverings on some equipment was torn, this meant it could not be kept clean.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The manager was signposted to the updated guidance and gave us assurances measures would be put in place immediately to mitigate potential risk of cross infection.
- We were not assured that the provider's infection prevention and control policy was up to date. Policies had not been updated to reflect the recent change in guidance regarding the use of eye protection when providing personal care. The management team were signposted to the latest government guidance.
- We were somewhat assured that the provider was preventing visitors from catching and spreading infections. A family member told us when they had visited the service on one occasion, they were not asked to wear Protective Personal Equipment (PPE) such as a mask, gloves and apron. One of the inspectors did not have their temperature taken or were asked about their COVID-19 status until another inspector prompted the registered manager to do so.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured the provider was facilitating visits for people living in the home.

Using medicines safely

- Overall, medicines were managed safely. However, records indicated people had not always received their medicine as required. One person who frequently refused their evening medication had not had this reviewed by their GP. One of the frequently refused medications was prescribed to control the symptoms of epilepsy. Records in the person's care plan did not demonstrate that the registered nurse had contacted the GP despite the care plan for this person having been evaluated three times and, on each occasion, it stated the person continued to refuse medication.

We found no evidence that people had been harmed however, 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.

The provider responded to these concerns after the inspection. They confirmed all the actions from the fire risk assessment were now completed. Cleaning regimes had been improved to include equipment and individual risk assessments were now in place.

- Staff we spoke with were able to tell us about all the risks they needed to be aware of when supporting people. Staff told us they referred to care plans and a summary report with a sheet of dietary needs for each resident.
- Records we looked at showed when people had falls or accidents, their care plans and risk assessments had been reviewed and actions taken to mitigate risks, where possible.
- Where a safeguarding incident had been identified, the relevant agencies had been notified and action had been taken by the service.
- Although training records showed some staff were yet to complete their safeguarding training; the staff we spoke with were aware of their legal duty to keep people safe from risk of abuse. They knew how and who to

report concerns to.

- Staff were aware of the whistleblowing policy and told us how they would raise concern, ensuring people were protected.
- People we spoke with told us they felt safe. A relative also told us, "We don't have any worries about [name] being safe, they [care staff] always contact us if they have any concerns or if anything changes.".
- People who wished to smoke were supported to do this safely. The home had improved their assessments to identify potential risk and had put the appropriate processes in place.
- When people required medicines to be administered on an 'as and when required' basis there was guidance in place for staff to follow so they would know when to give the medicine. The medicine records we checked showed this guidance was being followed.

Staffing and recruitment

- Staff we spoke with told us they had supervisions and felt supported.
- There were no issues identified with the service's recruitment processes.
- Nursing staff had their registration numbers checked to ensure they were legally registered to work as a nurse.
- Our observations during the day, indicated there was enough staff on duty to meet people's identified needs. People told us care staff were available when they needed help.

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The registered manager told us they had not implemented clinical competency assessments for the registered nurses. This meant staff had not been assessed in their role to ensure they were implementing learning from training and to ensure they were effectively providing support.
- The training matrix we were initially provided with, was not up to date. an up dated version has been provided which shows some training had been completed however there were still some gaps. We discussed this with the registered manager who had not scheduled training to address these gaps.
- Staff files we looked at evidenced that staff had received an induction.
- Staff told us they were well supported by the registered manager.

Adapting service, design, decoration to meet people's

- Further refurbishment was still needed in the service. The decoration in the service is very tired in some areas. We saw that the light shades had been removed from several bedrooms exposing bare light bulbs. This did not provide a warm and welcoming area for people to relax in. The registered manager told us these had been removed as they were dirty but had not been replaced. After the inspection the registered manager told us these had now been replaced.
- An audit of the environment which was completed by the maintenance officer, identified areas in need of decoration and new furniture. However, there were no current plans for when these improvements would take place. We will review the progress of these plans at our next inspection.
- We saw people making use of the garden during the inspection to enjoy leisure time and carrying out activities.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- Staff carried out evaluations of care plans to assess if people's needs had changed. However, care plans were not always updated to reflect these changes in a timely way.
- Care files looked at, evidenced that assessments of people's needs had taken place.
- The registered manager was involving professionals such as Speech and Language Therapists (SaLT), podiatrists and the mental health team, where appropriate, to ensure people's needs were fully understood. One health professional told us, "They [care staff] always take on board treatment advice."

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

- People told us they were happy with the food and drink they received. One person told us, "The food is ok,

my favourite is fish and chips." Another person told us, "The food is nice, I have what I want."

- Where people were at risk of malnutrition or due to a high BMI, this had been identified and appropriate action was being taken.

Supporting people to live healthier lives, access healthcare services and support

- People told us they were supported to access healthcare services when needed.
- People were involved in managing health conditions and people were able to tell us about the support they received.
- People's health conditions were understood, monitored and well managed.

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

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

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We found the provider was meeting the regulations around the need for consent and the effective use of the MCA and the basic requirements of the law had been met.
- People told us staff always sought their permission before providing them with support. One person told us, "They [care staff] do ask me if I need help, I don't always want help though and they will leave me alone until I am ready."
- The registered manager had identified where individuals were being deprived of their liberty in order to protect them and the required legal applications had been submitted to the local authority.
- The registered manager had also taken steps to identify where people had appointed legal representatives who could consent on their behalf.

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 requires improvement.
At this inspection this key question has remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect. Whilst individual care staff members may be caring the providers systems and processes do not mean people are always cared for.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Risk assessments were not in place for some service users who required specialised breathing equipment. This placed people at risk meaning the service was not always caring.
- The provider did not operate robust systems and processes. This meant we could not be assured people always received their care and treatment in a way that demonstrated that safe care had been given.
- People's cultural dietary needs were not always taken into consideration to reflect their diverse preferences. Two relatives told us their loved ones were not provided with culturally appropriate meals. One relative told us, "Mom has swallowing difficulties so we can't take the risk of taking food in for her now but they [the service] could do slightly spiced foods for her but I don't think they do." Another relative said, "The food, is something which dad does not always like, it's not what he grew up eating, that's for sure. We take food in sometimes such as chicken and rice. If they [the service] provided foods he liked this might help with his eating, he has lost weight."
- Issues we identified with missing light shades in bedrooms, poor standards of equipment and missing door handles does not promote a respectful and caring environment.
- People told us that staff treated them well and were kind and caring. We saw kind and caring interactions between people and staff.
- People were clearly comfortable and relaxed around staff members and were confident to make requests, which were responded to. Throughout the day we saw people smiling and laughing.
- People told us, they were treated in a dignified and respectful way. One person told us, "Staff knock on my door and ask if I need any help."
- Another person told us, "They listen to me and they speak to me well."

A relative told us, "I am very happy with the care [name] receives at Cole Valley. If I had concerns I would be the first to voice them."

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

- People's views were taken into account during residents meetings and people had the opportunity to make comments and suggestions.
- People we spoke with told us they knew if they had a concern they would be listened to.
- People said they were given a choice around what time they got up and went to bed. People told us they

could choose what time they wanted to eat. One person told us, "It's up to me when I go to bed, sometimes I like to stay up late and watch TV."

Is the service responsive?

Our findings

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

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

This meant people's needs were not always met.

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

At the last inspection there was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the provider was not meeting the regulations.

At this inspection we identified there was no longer a breach of regulation 9.

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 was aware of the requirements of the AIS and was able to describe how they would take steps to provide information in alternative formats if needed.
There was information provided in verbal format using a memory stick to play the information, for those who required it.
- However, the registered manager was not aware they could access the Royal National Institute for Blind People (RNIB) for information, guidance and products to enhance the lives and independence of people who are visually impaired.
- One relative told us they had provided staff with some cards, of key words translated, to help staff to communicate with their loved one, as English was their second language. The relative told us that at times there were staff members on duty who spoke the same language as their relative and they did not have any concerns.
- Some people told us they had received a care review and had the opportunity to discuss their care, but other people said they had not received a review and were able to contribute to their care and treatment.
- A relative told us they had been involved in care planning and had attended a care review but this had not taken place recently due to COVID-19 restrictions. However, another relative told us they had not been involved in developing the care plan for their loved one and had not been asked for any information. Another relative told us, they had to ask for an update about the changes to their relative's condition. A meeting was then arranged but only because they asked.
- The registered manager told us she wanted to develop the care reviews to make improvements.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

- People using the service were of different cultures and religions. One relative we spoke with told us they were no longer able to take their relative to their place of worship due to their physical abilities. They told us, "It was agreed at Mom's assessment with the local authority she should be taken out a couple of times a year to the [place of worship] but due to the pandemic this has not happened. It would be nice if this could happen from a cultural point of view." The relative told us they would discuss this with the registered manager again.
- Some people told us they enjoyed the activities which take place and we saw people enjoyed the activities which were on offer. However, the activity plan displayed was two weeks out of date. This meant people could not be sure about forthcoming activities for the day.
- One person told us that they enjoyed the ball games and making things but at the weekend they got bored because there were no activities. The activities co-ordinators worked Monday to Friday, meaning care staff were responsible for entertainment during the weekends. A staff member we spoke with told us, "At the weekend we sit in the lounge with residents, watch TV and have snacks." When we asked another staff member if there was something they could change what would it be, they told us, "To get more activities for people that would be the main thing, there is not much at weekends and the pandemic has caused havoc."
- People told us that the restrictions on visiting during the pandemic had been really hard and they had missed seeing their loved ones. Some relatives told us they had been able to speak to relatives on the telephone. One relative who was unable to speak to their loved one due to their health condition told us, "They have been happy to give us feedback on the telephone every day and we have been having window visits two or three days a week."

Improving care quality in response to complaints or concerns

- People told us they knew how to raise a complaint if needed. One person said, "If I had a complaint I would speak to the carer." Another person told us, they thought they would be listened to and knew who the manager was.
- A relative told us they found communication from the staff was poor at times. They said, "They [the staff] do not communicate well, they have not communicated about visiting and I expected them to be more communicative. They were very slow in lifting restrictions and staff we spoke to about the lifting of restrictions and visiting really did not know what the plan was. After several calls I had to speak to the manager in the end to get an answer."
- The registered manager kept a record of any complaints received which were investigated and responded to.

End of life care and support

- The GP told us, "This practice is involved with care decisions, especially those relating to end of life and patients should have a Respect forms in their notes. The nurses do contact the practice appropriately for support and guidance."
- At the time of the inspection there was one person being supported with end of life care. The relatives of this person had been able to visit their loved one when their health had deteriorated, adhering to government guidance.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement and there was a breach of regulation 17 (Good governance). The provider had not established or maintained effective governance within the service.

At this inspection this key question has now deteriorated to inadequate and we found there was a continued breach of regulation 17 (Good governance). The provider had not established or maintained effective governance within the service. We also found there was a breach of registration regulation 18 notification of incidents. The provider had failed to notify us of a serious incident.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The management of safety, risk and governance had not been effective. We identified concerns about people's safety during the inspection due to the lack of oversight. Actions had not been taken by the registered manager to ensure the systems and processes were robust and operated effectively. The registered manager told us this was due to them supporting another manager, at another service. The registered manager told us they had spoken to the provider as they had recognised they were not able to effectively monitor and manage the service, whilst supporting the other manager.
- There was an auditing system in place, but this had not been operated effectively and had failed to identify the on-going concerns we found during the inspection.
- The registered manager had failed to maintain up to date records for us to review on the day of the inspection. Some information we requested could not be provided until after the day of inspection as it was not up to date or in place.
- Although the registered manager was aware of the need for COVID-19 risk assessments for people using the service and staff members these had not been completed. This placed people at increased risk of harm from COVID-19.
- Audits had failed to identify accurate records relating to people's care needs were not always being provided. For example, risk assessments for equipment used to manage specific known health conditions, were not consistently in place to provide care staff with guidance.
- Equipment which was not included on the cleaning schedules had not been identified by the infection prevention and control audit. The audit failed to identify the concerns we found on the day of the inspection. This included poor standards of hygiene, empty hand soap dispensers, missing bins and toilet roll holders.
- Checks of the building and equipment safety were completed; however, these did not include actions taken when concerns had been identified. For example, in relation to missing window restrictors, broken

water temperature thermostat and a broken sluice. The provider audit process did not include a system to ensure such actions were completed therefore safety issues had not been addressed.

- Audits had failed to identify the continued, refusal of medication for one service user had not been discussed with the GP.
- Information requested by CQC to demonstrate that the providers were meeting regulations in an open and transparent way was provided, however, this was not always provided in the specified timeframe. This hindered the inspection process.

Continuous learning and improving care

- The registered manager told us they had not implemented reflective conversations at the time of this inspection. Reflective practice gives the registered manager and the team members, the opportunity to discuss things which have and have not gone well and look at how they could implement changes, to reduce the risk of recurrence and help to drive improvement.
- The provider and registered manager had not kept up to date with changing guidance to ensure best practice was always followed. They also failed to ensure policies had been updated to reflect these changes.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the service was well managed. This placed people at risk of harm.

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

- Prior to this inspection, we were made aware of an incident which was investigated by the Coroner. CQC were not notified of this serious incident.

This is a breach of The Care Quality Commission (Registration) Regulation 18 (Notification of incidents) 2009. We did not identify any other incidents during the inspection which we had not been notified of.

- Staff we spoke with told us that they felt supported by the management team and said if they made suggestions they would be listened to.
- The provider had displayed their previous inspection rating as they are required to by law.

Working in partnership with others

- People told us they were supported with their appointments and records of health professional visits supported this information.
- Care records demonstrated that when care staff identified concerns with people using the service, these were raised with health professionals, when support was needed.
- Health professionals we spoke with told us the registered manager and staff members contacted them appropriately and followed their advice and guidance. One health professional told us, "I have no concerns, if I ever raise anything with staff it is always acted on. People are well looked after." Another health professional told us, "The leader of the Care Home Team has found the registered manager difficult to get in touch with on occasion, but I hope this was just teething problems."

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that risk to people were effectively managed. People were exposed to risk of harm due to unsafe risk management systems including poor Infection Prevention and Control practices. As a result, they people were exposed to the risk of serious harm.

The enforcement action we took:

We issued a Warning Notice to ensure improvements to Infection Prevention and control were made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance systems were inadequate. Potential risk and areas of improvement were not identified. Action had not been taken to make required improvements. The provider had not ensured governance arrangements within the service had been established.

The enforcement action we took:

We issued a Notice of Proposal imposing positive conditions to help drive improvements.