The Fremantle Trust

Lent Rise House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Lent Rise House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. We regulate both the premises and the care provided, and both were looked at during this inspection.

Lent Rise House can accommodate 60 people within four units, each of which has separate adapted facilities. The service cares for adults, including people living with dementia. The premises are modern and purpose-built. People live in their own bedrooms and have access to communal facilities such as a dining and lounge areas. At the time of our inspection, there were 54 people living at the service.

Our last inspection was completed on 25 July 2016 and 26 July 2016. We found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not safely managed. The storage of medicines exceeded safe temperature limits and the provider had failed to ensure appropriate action was taken. The rating for key question safe was subsequently requires improvement. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve key question safe to at least good. We received the action plan on 31 August 2017.

We undertook an unannounced focused inspection of Lent Rise House on 13 December 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive July 2016 inspection had been made. We completed this focused inspection because we had received concerning information from the local authority, police and clinical commissioning group. Information we received included allegations that people had sustained avoidable harm, that medicines were not properly managed, that people had experienced abuse or neglect and that there were ineffective management. The team inspected the service against two of the five questions we ask about services: "is the service safe" and "is the service well-led?" This is because the service was not meeting some legal requirements. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

The provider is required to have a registered manager as part of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, there was no manager registered with us.

The overall rating for this service is inadequate and the service is therefore 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.

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 found people had either sustained harm, or were at high risk of enduring harm. The safety of people's care and treatment was unsatisfactory. Avoidable incidents and accidents had occurred, including slips, trips, falls and fractures. People had unexplained injuries, such as bruising which were not adequately reported or investigated. Local authority and police enquiries were commenced in an attempt to determine what the causes of some of the injuries were, and where appropriate, any staff responsible. Multiple staff were suspended from duty and under investigation at the time of our inspection. The provider had not made referrals to other regulators, but completed these when we asked.

People's risk of harm and actual harm sustained was increased by poor risk assessments, nursing care plans and a lack of regular reviews. Advice and guidance from community healthcare professionals was often not incorporated into the care people received. Some documentation was inaccurate and other care documentation was missing or never completed.

People's medicines management was unsafe. There were numerous errors in medicines processes. These included ordering, storage, administration, documentation and reporting of incidents.

Staff described a challenging workplace environment. Many staff deployed at the service were from agencies and did not have adequate knowledge of the people who lived at Lent Rise House. People and relatives were sometimes unaware of the management of the service and explained their opinions were not always considered.

The provider had identified the service required improvement and commenced an action plan in August 2017. However, interventions to address shortcomings were not measured regularly enough to ensure they were sufficient or sustained. The lack of effective oversight of the service had led to poor governance of the systems and process meant to be in place to provide safe, quality care for people.

We provided information about our findings to the local authority, commissioners of people's care, the district council's environmental health office and the local fire inspectorate.

We found seven breaches of the regulations.

You can see what action we told the provider to take at the back of the full version of the report.

Full information about our regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

People were not protected from abuse or neglect.

People at high risk of harm had sustained avoidable injuries.

Nursing risk assessments and associated care plans were unsatisfactory and not reviewed regularly.

People's medicines were not safely managed.

Is the service well-led?

Inadequate

The service was not well-led.

The provider failed to comply with a condition of the registration as there was no registered manager in post.

The service failed to submit notifications to us so that the quality of the care could effectively be monitored.

Risks were not always acted on and when they were, actions were frequently not sustained.

There was a negative workplace culture and some staff resisted reporting appropriately when people experienced harm.

Information from external agencies was not always used to ensure the quality of the service.

Lent Rise House

Detailed findings

Background to this 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 was planned to check 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.

Our inspection was prompted in part by notifications of incidents following which people who used the service were subject to alleged abuse, neglect or sustained a serious injury. Some incidents are subject to a criminal investigation and as a result our inspection did not examine the circumstances of the incident. However, the information shared with us about the incident indicated potential concerns about the management of risks associated with unsafe medicines, unexplained injuries and governance of the service. This inspection examined those risks.

Specific incidents were reported to the police and local authority safeguarding team. At the time of our inspection, each agency was conducting their own enquiries. Several staff at the service were suspended without prejudice, as allegations and incidents were under investigation. Some registered nurses were referred to the Nursing and Midwifery Council (NMC) and the performance of others was under scrutiny.

Our inspection took place on 13 December 2017 and was unannounced.

Our inspection was completed by three adult social care inspectors. Two of the inspectors are registered nurses.

We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also checked feedback we received from members of the public, local authorities and clinical commissioning groups and the police. We checked records held by Companies House, the Information Commissioner's Office, the local fire inspectorate and the district council environmental health office.

We spoke with seven people who used the service and four relatives who visited during our inspection.

We spoke with the provider's regional director, quality assurance manager and estates manager. We spoke with the acting clinical lead, four registered nurses and five care workers about people's support and treatment. We spoke with two kitchen workers, an administrator, two cleaners and a staff member from another service of the provider. We also spoke with three community healthcare professionals.

We looked at seven people's care records, five staff personnel files and other records about the management of the service. After the inspection, we asked the provider to send us further documents and we received and reviewed this information. This evidence was included as part of our inspection.

Inadequate

Is the service safe?

Our findings

We received mixed comments from relatives and people we spoke with during our inspection. We asked people and their relatives about whether the service was safe. People and relatives expressed concerns with the safety of care and treatment provided by the service. One person told us, "There's only one horrible nurse. [They have] come in and seen me sick in my bowl and just left me. I complained once, but they don't listen. I wanted another sick bowl but they don't come back. One [staff member] at night is horrible. [The staff member] leaves the light on and I have to get out of bed and [switch it] off."

We spoke with a relative and they told us, "[The person] has been here for more than one year. There are ongoing concerns. There have been a couple of falls. One of them was when staff left [the person] sitting on the toilet. [The person] fell off and [sustained a fracture]. That was when my concerns started. [The person] was taken straight back here from hospital...I was in [the person's] bedroom when they [staff] were attending [to the person]. One member of staff pulled [the person] over, unaware of the stitches and wound. I had to tell them [about the wound]." The person had sustained pain as a result of the staff moving and handling procedures.

Another relative told us, "I think [the person] needs a thorough assessment. [The person] has lost a lot of weight since she came here. One carer came up to [the person] one day and hauled [them] out of the chair. I think the member of staff was agency. Since Friday [the person] has been non weight-bearing." We asked the relative if the person's mobility had been reviewed by staff or multidisciplinary health care professionals. The relative told us that had not happened.

A relative told us that bruising was noted on the person which was unexplained. The relative showed us a photo of the bruising which we saw demonstrated the affected area of the person's body. The relative told us a meeting was held on 11 December 2017 to discuss what was "going on" within the service. The relative told us they had knowledge of at least three people who sustained fractures.

Systems, processes and practices to safeguard people from abuse and neglect were inadequate. Our inspection was partly prompted by a large number of allegations about unexplained harm to people who used the service. We were provided a copy of the staff training matrix on the day of our inspection. Staff were required to complete safeguarding training as part of their induction period, and in an ongoing basis. More than half the staff had either not completed this training or their training had expired. This meant that staff knowledge of protecting vulnerable adults from the risks of harm was not up-to-date.

The safeguarding adults' information held at the service was outdated. The information about how management or supervisors should deal with such allegations was dated 11 July 2013. In addition, the safeguarding information did not have a flow chart of the process to follow if anyone had concerns. We noted contact information for escalation of such concerns related to a previous operations manager who had left the service some time ago. Without the current guidelines for safeguarding, staff that managed allegations of abuse or neglect did not have necessary information for the protection of people who used the service.

Fact-finding and investigations when abuse or neglect occurred were not always completed at the service. When we asked for evidence of steps the service took to check details, obtain statements from staff, review recorded care information, photograph wounds or injuries, these documents were not available. We asked how many actual reports of abuse or neglect were known at the time of our inspection. The staff at the service were unable to provide an answer. We asked the local authority safeguarding team to advise us of the number of enquiries they were handling under The Care Act 2014. There were 13 incidents under investigation by the local authority. The service had failed to maintain a register of the abuse and neglect allegations and had a lack of oversight into the progress or outcomes of investigations. There was no designated lead staff member at the service-level who was responsible for ensuring that people did not continue to be subject to alleged abuse or neglect.

During our inspection we spoke with one member of staff who was concerned about historical alleged abuse by another member of staff. They told us they had witnessed a member of staff wilfully ill-treating a person who used the service. The staff member told us they reported this to the provider earlier in 2017. The staff member felt this was not acted on and was never told what actions, if any, were taken in the matter. We raised this during our inspection with the management team. The management team said they will look into this with immediate effect. We noted the member of staff who had carried out the alleged abuse was working at the service during the day of the inspection. We requested that the provider reported the safeguarding concern we identified to the local authority. They confirmed they would report this. We found this was reported to the local authority. However, the provider told us they would wait for advice from human resources before they took any action regarding the staff member. This meant the staff member continued to have contact with people who used the service at the time of our inspection. The member of staff was subsequently suspended by the provider.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not adequately assessed and their safety monitored and managed, so they were supported to stay safe. We saw from people's care folders that risk assessments, such as those for falls risks and moving and handling were present. However, we noted that some risks assessments were outdated and others were not sufficiently reviewed. There was a lack of engagement for the risk assessments with people who used the service and relatives. Risk assessments also did not take into account the advice from multidisciplinary healthcare professionals. This meant risks to people were not accurately assessed, documented, mitigated or reviewed and therefore people were susceptible to further harm.

We found multiple people sustained harm from falls or related incidents from poor risk management. This included serious harm to people, such as fractures. We examined falls incident reports. We found these were appropriately completed by care or nursing staff, but not always provided to the management team. Instead, they were filed in the person's care folder on the unit. The management told us the latest home manager had collected falls incident reports from the units and taken them for review in an attempt to collate the information. We saw staff had provided some details on the report forms, but failed to document any actions to prevent further falls. We also found that some people repeatedly had falls, but this was not detected or explained in the falls reports. Staff were unable to provide an accurate number of incidents that people prone to falls were involved in. Some staff did not know which people were at highest risks for falls. The number of falls could not be accurately determined as the service could not confirm if every fall was reported and where all incident reports were stored. People continued to be at risk of, or sustain further harm, as the service had not mitigated the known risks.

The mechanism of some injuries that people sustained, such as fractures, were unexplained and remained

under investigation by other agencies, such as the safeguarding team and local police. For example in one case, a person who did not move out of their bed had sustained a fracture. They had not been involved in a fall or any other injury that would cause a fracture. Other people had unexplained bruising, injuries to their skin integrity such as cuts, bruises and pressure ulcers. Inadequate care was provided and recorded when some of these injuries occurred. For example, we found evidence that registered nurses had not completed 'body maps' to show where the injury occurred, had failed to photograph and the track the progress of the injury healing and had failed to plan and complete wound dressings. This meant people were at risk of further harm from the failure to sufficiently and consistently deal with existing injuries and their treatment.

At our last inspection, we found changes were required to the storage of medicines at the service. We found multiple failures throughout the service's medicines management process. These included the ordering of medicines. We found evidence that medicines were not ordered on time, that medicines were often out of stock leading to people not receiving them, and staff sometimes failed to take action to rectify the issues. Due to the poor ordering process, the staff frequently requested prescriptions from the GP outside the medicines ordering cycle, and relied on the pharmacy to quickly provide stock in an ad hoc fashion. The medicines ordering process meant that people had missed out on doses of a variety of tablets and topical (skin) creams. This meant people were sometimes placed at risk of harm from not receiving their prescribed treatments.

Some staff had received training in "medication" according to the service's training records at the time of our inspection. The repeat date of the training was 2019. However, when we asked for evidence of competency assessments for staff who administered medicines, we were told they could not be found. The provider could not ensure staff who were involved in medicines handling and administration completed the practise safely.

Following our last inspection, the provider submitted an action plan stating action would be taken to correct the storage of medicines to ensure they were at a safe temperature. An air-conditioned room was used to store medicines and checks of the temperatures in the room and storage fridges were completed. However, at our inspection, we found medicines trolleys on the ground floor were not stored in the air conditioned room. This meant medicines were still not stored in line with the manufacturers' guidance and the provider had failed to ensure their own action to achieve this was always followed.

There were multiple errors with medicines which meant people suffered harm or were at risk of harm. We looked at the medicines administration records and found repeated errors in documentation. For example, we found transdermal patch application records were not always completed. A transdermal patch is a medicine adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin and into the bloodstream. We asked a member of staff why they were not recording the site of where and when the patch was applied on the form. We were told that the date and time of application was written on the patch when the patch had been applied to the person. We reported this to the management team during our feedback. This practise was not in line with medicines administration guidance or policy.

We found insufficient information relating to covert medicines. Covert medicines are when the item is disguised in food or drink so the person will consume the product without rejection. We did not see confirmation from a pharmacist relating to a person having their medicines covertly. We saw capsules had been prescribed. If capsules are taken apart to remove the contents this may alter the properties of the medicine. The medicine then becomes unlicensed and would not be covered by the manufactures product licence. In addition, staff should only give licenced medicines in an unlicensed way if there is written direction form the pharmacist and is clearly documented in the person's care plan. Also some food and drinks may affect the way the medicine is absorbed. If capsules are opened and given to a person without

directions from the prescriber and without making the appropriate checks the provider could be held liable for any harm caused. People were at risk of side effects having their medicines in this way. We discussed this during our feedback with the management team.

We noted multiple missing signatures on medicines administration records. For one person, we saw this included more than one day in December 2017. There was evidence of staff handwriting prescriptions on the medicines records without double-checking or records of phone orders from the GP. The staff had not liaised with the community pharmacist to ensure the medicine was printed onto the medicines record. We showed all of the examples we found to the senior managers at the time of our inspection. The management team acknowledged that this was unsatisfactory documentation by staff who administered the medicines. When we looked at evidence of medicines errors recording to management, there were either none recorded or when they were reported, they were not corrected and acted upon.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were not followed to ensure people were supported by staff with the appropriate experience and character. We looked at five recruitment files of staff that had commenced in post since our last inspection. We found these did not contain the required information. For example, the first file we looked at did not have the staff member's photograph, an application form, a health questionnaire and occupational clearance. The second file had no photographic evidence of the member of staff, no references, and no enhanced disclosure and barring service checks (DBS). The third file we looked at did not contain the staff member's photo, a DBS check, proof of identification, or a start date. The fourth file we saw did not contain proof of identification or health clearance. The fifth file did not have proof of identity. We discussed this with the management team and requested them to address this.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from risks related to the premises and equipment. Systems were in place to protect people, but some areas required improvement to ensure harm did not occur. We noted a door leading to a boiler or plant room was open and therefore not locked. People walked past the door and could have tripped on the high step upon entry or accessed pipework or electrical equipment. We pointed this out immediately to the acting clinical lead and asked that the door be closed and secured. We saw "personal emergency evacuation plans" (PEEPs) were in place for staff to follow in the event of an emergency, such as a fire. Fire drills were carried out. However, these were too infrequent and did not ensure all staff were aware of how to manage people in the event of a fire. We found the last recorded drill was 13 April 2017. The prior drill to that occurred on 15 September 2016. We did not see evidence of the staff involved in the drills or any documentation of how long the drill took and if there were any areas to follow up on. Some staff had not completed mandatory fire safety training and the majority of other staff's training was overdue. We passed this information to the local fire inspectorate.

Emergency procedures and contact numbers for out of hours assistance was in place. We saw the nearest provider's service and housing association contacts were listed. We saw evidence of maintenance records and any issues were reported to the housing association and contractors. Additional safety examinations were carried out such as electrical checks, hoist and sling checks, gas safety and portable appliance testing.

We checked whether sufficient staff were deployed to safely meet people's care needs. At the commencement of our inspection, we met a staff member who was working at Lent Rise House, but

employed at another of the provider's locations. They told us they were responsible for completing the rota for the following two weeks. The staff member said they did not have knowledge of the people who used the service, and was unable to provide information relating to their dependency or expected numbers of staff. We asked the acting clinical lead about the number of staff deployed and they provided us with the information. We heard that there were vacancies for both nursing staff and care workers. Due to the vacant positions and the number of staff suspended pending investigations at the time of our inspection, there was a high level of agency staff deployed. When we asked the management whether any planned shifts were not filled by substantive or agency staff, they confirmed the full staffing complement on the rota was deployed.

We observed staff presence within all four units of the service. We noted that staff were visible most of the time, although there were occasions when people were left unattended in communal dining rooms or lounge rooms. We observed that some of the people were asleep or slumped over in the absence of staff. However, we found that adequate staff were deployed. When we spoke with agency staff, they did not have a good understanding of specific people who used the service. For example, nursing staff told us it took longer to complete medicines rounds because they were not familiar with people's requirements. Care workers were more knowledgeable about people's needs. Permanent staff described the difficulty in supporting people when a high percentage of agency workers filled shifts in a unit at the same time. They told us they felt they had to continually guide and instruct the staff as the agency workers had insufficient information and failed to read care plan information.

Inadequate

Is the service well-led?

Our findings

We asked people and relatives if they had any issues or concerns about the service. One person told us, "I have an issue with money. It took me eight days to get five pounds. I had to borrow it from friends in the end." The person told us staff kept their money in a safe but when they requested some of their money the person was made to wait for it. We asked the person if this has been reported to management. They told us, "They know, I've told them. I told them who...are they to say I can't have my money." The person told us, "By saying this to you nothing will change." We asked if they would know how to make a complaint and they told us, "I would write it down on paper." Another person told us, "On the whole they [staff] are nice but the agency ones are too busy." We asked the person if they felt listened to. The person said, "They don't take a lot of notice, we have residents meetings and nothing changes."

A relative commented, "We don't know what's going on. None of the nurses are our regular nurses. I'm not made to feel welcome anymore. The staff have been demoralised over the last few months." We asked the relative about the training staff have. They told us, "Some are ok, some are not, and some don't have a clue. Some staff really don't know [the person]. I have said I don't want some staff looking after [the person]. We had an emergency meeting last week. We discussed issues such as food, lack of communication and the general standard of care. The test will be what was promised at the residents' meeting."

Another relative told us that, "Trying to communicate with the provider is a joke." They expressed they attempted to raise issues about safety of a person who used the service and were not listened to. They said they did not know which staff member to approach and were concerned the person was at risk of harm or would sustain harm.

The service had no registered manager for over a year. A condition of the location's registration with us is that a manager must be registered. A home manager was in post during most of 2017 however they left the service. Interim management arrangements were then put in place by the provider. An experienced manager was recruited to work at the service. It was their intention to apply for registration. They were being supported by a peripatetic (roving) manager who worked for the provider. Both of these managers were on leave at the time of our inspection. The service was operated by the acting clinical nurse and a regional director in the absence of the service's management. Both were new to the provider and lacked some knowledge of people, staff, and service systems and processes.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications and they must be reported to us "without delay". This ensures we can effectively monitor the safety of people and quality of care between our inspections. The provider had not ensured we were made aware of all relevant incidents. There were multiple incidents which had not been reported to us or the local authority at the time they occurred. At the time of our inspection there were ten incidents which had not been reported when they occurred. Further reportable incidents were shared with us after our inspection. These included unexplained injuries and bruising and other safeguarding events. Prior to our inspection, we found the new home manager however was aware of their responsibilities towards this requirement and

commenced reporting the incidents as they arose and as historic events came to light. However, we could not be confident people were protected from the risk of harm because staff and managers during 2017 did not understand their responsibilities to protect people.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service did not have a culture where staff were open about reporting any mistakes that had occurred, such as medicine errors and accidents. The provider had procedures to advise staff on how to raise concerns through whistle-blowing. Whistle-blowing is raising concerns about wrong-doing in the workplace. However, staff did not use these and mistakes or accidents were not dealt with in an open and transparent manner. This meant people were placed at risk of harm from poor practices at the service.

There was a negative workplace culture amongst the staff who worked at Lent Rise House. Regular staff meetings were not held to communicate changes, pass on valuable updates or information, and listen to staff ideas or opinions. During our inspection, staff felt comfortable speaking with the inspection team. They told us they did not always know who was managing the service, they did not always feel comfortable speaking with the management and there was a divide between the permanent staff and the agency workers. Some staff told us they would not report matters to the management as they feared that they would be singled-out or blamed for matters that affected people's care. We noted some positive team working within the units during our observation. However, the difficult context of people's safety and good leadership had created workplace stress for a small number of staff we talked with. They became emotional and told us they did not always feel valued or appreciated. We encouraged these staff to continue to focus on the needs of people and signposted them to external agencies that could assist with their distress.

There was ineffective monitoring by the provider of the quality of care at the service. We found regular visits were made by senior managers from the provider's head office to assess the quality of people's care. We saw two comprehensive audits were carried out in 2017. The provider used a system of rating services similar to that used by us. The most recent provider audit of Lent Rise House in August 2017 resulted in a rating of "requires improvement". Various actions were recommended to improve practice. We were told the provider placed the service in its own version of 'special measures' following this audit and dedicated additional resources to help make improvements. This included a regional director spending more time at the service. However, we found several areas where regulations were not met despite the support from the provider's quality and management teams.

An action plan to improve the areas of risk or harm to people was commenced by the service on 21 August 2017. We saw this was updated, but not frequently enough based on the risks identified. In the action plan we saw risks were rated as low or medium, but evidence of the harm and potential harm to people who used the service demonstrated there were some areas of high risk. A "manager's workbook" was provided to us as part of our inspection. This was an electronic spreadsheet containing monitoring and improvement checks submitted by the home manager to the provider's head office monthly. Some areas were already rated as high risk and this contradicted the service's action plan. Areas that were covered by the workbook included compliments, complaints, staffing, recruitment, finance and medicines. We noted significant findings where people had sustained harm. For example, there were 113 slips, trips or falls recorded between January and September 2017. Although actions to analyse falls were on the service's action plan, there was no evidence that interventions were taken by management to prevent further harm to people. The "manager's workbook" contained no information in any area for October and November 2017. This showed the provider had not ensured the service continually improved and acted on inadequate areas of care.

The findings of audits and checks of the service by community healthcare professionals and other regulators

were also not always properly acted on to rectify failings. For example, we found community-based multidisciplinary staff such as registered nurses and dietitians had visited the service in October, November and December 2017. The healthcare professionals had checked various areas of people's care such as medicines management and nutrition. A community pharmacist from the supplying pharmacy had also completed a comprehensive audit and report. Despite the areas for improvement noted in all of the audit reports, and the action plan maintained by the service, no action or a lack of action by the provider meant the harm to people was sustained.

We saw the environmental health officer (EHO) had inspected the service in August 2017. A score of one out of five was assigned, with 26 requirements, most of which were required "immediately." We saw the provider had taken action to correct the deficiencies. However, poor food preparation and hygiene meant people faced continued risks of harm. We saw speech and language therapists had reviewed people's risk of choking, and recommended pureed foods. The provision of pureed food would decrease the risks to people whilst eating. We saw evidence that on two occasions, pureed foods were prepared by a chef for people at risk of choking. This was left for staff to serve to people in their units. However, we were told people did not receive the food. This was confirmed from written documents at the service. We also noted that nursing records were not available to show what foods people consumed during these days when the pureed food was not provided. This led to the risk of choking and potentially pneumonia. Although correct documentation for food safety and hygiene practises was commenced after the EHO visit, at the time of our inspection the records could not be found and a single piece of paper was used to record some food temperatures. There was no evidence of cleaning or disinfection. We found food stored at unsafe temperature levels on the units, evidence of expired food in unit kitchens and food and other products where the expiry date was not labelled. Inspection findings and advice from the district council's EHO to improve food hygiene practises were not sustained. Due to the risks to people we identified related to the governance of food hygiene, we passed our findings to the district council's EHO.

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

Records were not always well maintained at the service. We identified other failings in the service's documentation. For example, the complaints log did not contain any entries for 2017. Some information was located on the service's computer system which indicated the type and number of complaints. However, the original complaint record (for example letters or e-mails) and how they were responded to could not be found. Some records were requested several times during our inspection and were not located by staff. These needed to be sent to us afterwards, once management staff had located them. A small number of records were not located and therefore not submitted to us as evidence of good governance.

We looked at whether the service worked in partnership with other agencies to ensure people received safe, quality care. Information from our monitoring of the service prior to our inspection showed that people were at risk of malnutrition or suffered weight losses. We looked at the management of people's diet and what actions the provider had implemented to ensure people had access to a healthy lifestyle. The service used the "malnutrition universal screening tool" (MUST) to identify people who may be at risk of malnutrition. We found care records for people were not accurate and did not correspond with the person's assessment. For example, we saw one person who had been assessed by a dietician in February 2017. Staff were advised to have "food first strategies". This is when people's food is fortified by extra calories from fats and carbohydrates. We asked senior staff and the acting clinical lead what food first strategies were. They were unable to explain what this was. One member of staff said, "I think the kitchen give them extra calories."

We saw that the service had not worked effectively with community partners to ensure a well-led service

which provided appropriate care to people. We saw evidence that healthcare professionals had visited people to review their needs on multiple occasions during 2017. These were people at high risk of dehydration and malnutrition. We saw community partners had reviewed people's needs, made appropriate notes and spoken with staff during successive visits. When we checked care records, we saw the service had not always followed the advice of the community healthcare professionals. A dietitian had made recommendations about the food intake for multiple people assessed as high risk of malnutrition. Despite this, we found evidence already at risk continued to lose weight. People were not weighed in accordance with the dietitian's advice. This meant the service could not effectively monitor for further weight loss and contact the dietitian. We found evidence that people had sustained more weight loss, but not evidence that the staff contacted any members from the multidisciplinary team. The local authority and clinical commissioning group had best practise guidance available for weight loss management in care homes. However, staff including the kitchen workers, did not have knowledge of this and failed to follow the recommended guidance.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. We found there were no records at the service to show that the duty of candour requirement was being met.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission without delay of the incidents specified in this Regulation which occurred whilst services were being provided in the carrying on of the regulated activity, or as a consequence of the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not appropriate, did not meet their needs and did not reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that persons employed meet the conditions in the Regulation. The registered person had failed to ensure that the following information was available in relation to each such person employed: the information specified in Schedule 3, and such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 20 HSCA RA Regulations 2014 Duty of candour

The registered persons had not acted in an open and transparent way with relevant persons in relation to
care and treatment provided to service users in carrying on the regulated activity. As soon as reasonably practicable after becoming aware that notifiable safety incidents had occurred the registered person had not: provided an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knew about the incidents as at the date of the notifications; advised the relevant persons what further enquiries into the incidents the registered person believed was appropriate; include apologies, and be recorded in a written record which is kept securely by the registered person.

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 Care and treatment was not provided in a safe way for service users. The registered person failed to satisfactorily assess the risks to the health and safety of service users of receiving care or treatment; do all that was reasonably practicable to mitigate any such risks; ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely; ensure that there were sufficient quantities of medicines to ensure the safety of service users and to meet their needs and ensure the proper and safe management of medicines.

The enforcement action we took:

We imposed urgent conditions on the location'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 Service users were not protected from abuse and improper treatment in accordance with this regulation. Systems and processes were not operated effectively to prevent abuse of service users. Systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

The enforcement action we took:

We imposed urgent conditions on the location's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The registered person had not established an effective system to ensure compliance with regulations 8 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not always take mitigating action where audits, monitoring and assessment systems identified risks relating to the health, safety and welfare of service users and others.

The enforcement action we took:

We imposed urgent conditions on the location's registration.