Hillsborough Residential Home Limited

Hillsborough Residential Home

Inspection report

Southern Road
Callington
Cornwall
PL17 7ER

Tel: 01579383138
Website: www.hillsboroughresidentialhome.com

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04 April 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Hillsborough Residential Home ("Hillsborough") is a residential care home that was providing accommodation and personal care to 21 people aged 65 and over at the time of the inspection. Hillsborough Residential Home Limited also provided personal care to people in their own home. They were providing support to five people; four of whom received personal care.

People's experience of using this service:
•People did not always receive their medicines safely and were not always protected by infection control practices.
•People did not always have the required risk assessments in place relating to their health and social care needs, to help keep them safe.
•Staff were not always recruited safely to ensure they were suitable to work with vulnerable people.
•Systems of leadership and governance did not ensure that there were effective checks of the quality of the service taking place.
•Staff had not always received the appropriate training, professional development, and supervision to carry out their duties.
•People and relatives were positive about the service and the care given in the residential home and in their own homes. People told us the food was delicious.
Rating at last inspection: The rating at the last inspection was Requires Improvement (Report published 05 April 2018).

We found seven breaches of the Health and Social Care Act (2008), and made recommendations in respect of the environment, and the Accessible Information Standard (AIS).

Why we inspected: We inspected the service in line with our inspection methodology. We followed up on the breaches of Regulations and the recommendations from the previous inspection.

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

Follow up: The overall rating for this registered provider is requires improvement. Going forward we will continue to monitor this service and plan to inspect in line with our reinspection schedule for those services rated requires improvement.

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

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 always safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Hillsborough Residential Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on the 02, 03 and 04 April 2019.

Inspection team: The inspection was completed by two inspectors, one pharmacist inspector and an expert by experience. An expert by experience is someone who has experience of older people's services.

Service and service type: Hillsborough Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The provider also operated a domiciliary care agency (DCA). It provided personal care to older adults living in their own houses. Not everyone using this part of the service receives a regulated activity. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

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. The registered manager was also the provider.

What we did:
Before the inspection:
•We reviewed our records. This included notifications which providers are required to send us, to tell us

about certain events.
•We reviewed the Provider Information Return (PIR). Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection:
•We met everyone and spoke in detail with six people and two relatives.
•We spoke with three people and four relatives in respect of the DCA.
•We spoke with ten staff members in respect of the care home and one staff member in respect of the DCA.
•We reviewed six people's care records for the care home and two people's care records for the DCA, including one person's medicine records
•Three personnel records of recently recruited staff and records of training
•A training audit.
•We reviewed the records the provider kept in respect of the maintenance and monitoring of the service.
•We spoke with the district nursing team, podiatrist and trainer for the provider

After the inspection:
•We contacted the local authority adult safeguarding and quality assurance teams.
•We spoke with the fire service.
•We spoke with the allocated GP for the service.

Requires Improvement

Is the service safe?

Our findings

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

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

Using medicines safely
•People did not always receive their medicines as prescribed. People identified as being at risk of constipation were not given their prescribed medicines to treat this. One medicine was out of stock since 21 March 2019. One person was given a double dose of their prescribed laxative medicine. Following this error their GP had not been contacted. We referred this concern to the local authority safeguarding team and spoke with the GP and district nurse to ensure these people were reviewed quickly.
•The provider did not ensure there was an appropriate policy in place that governed the giving of medicines to people. Also, the provider was not aware of the National Institute for Health and Care Excellence (NICE) guidance. NICE clinical guidelines are recommendations, based on the best available evidence, for the care of people by healthcare and other professionals. Clinical guidelines enable those caring for people to reassure them that they are following evidence-based practice. This meant that people's medicines were not always managed in line with best practice. For example, there was no guidance for staff to make consistent decisions about when to give a medicine prescribed to be given 'when required'.
•Medicines audits did not identify areas of poor medicines management, to help enable ongoing improvements. For example, the audit had failed to identify liquid medicines that should have been discarded three months after opening were still in use.
•Staff were not using a consistent coding system to record whether people's medicines had been given. The code 'made available' was used often with no recording of whether the medicine had been observed as being taken. For 'as required' and prescribed medicines, different staff used different codes. This resulted in some prescribed medicines being treated as 'as required'. This meant people were unlikely to have their medicines as their GP expected.
•Two people were on pain medicine. Both people were unable to express how they were feeling because of cognitive difficulties. However, staff did not use pain assessments to record their pain. This meant staff had no available means to ensure people's 'as required' medicines for pain was being given when needed.
•Some people required pain medicine in the form of a skin patch. Staff did not rotate the patches as they should, according to manufacture guidelines. Therefore, increasing the risk of skin irritation.
•One person had epilepsy. They were prescribed an emergency medicine to manage seizures. Staff had not received training on how to identify and treat seizures, when asked, staff gave inconsistent answers about the support they would provide. In addition, they told us, they would not feel confident about administering the emergency medicine.
•People's topical creams and lotions were recorded on Topical Medicine Administration Records (TMARs) along with body maps to state where they needed to be applied. The records did not detail how often the topical cream should be applied.
•Medicines stored in the medicine's fridge were not stored securely. This was in an open area and the fridge was unlocked, meaning that medicines were accessible to anyone. Other medicines were stored securely.

Assessing risk, safety monitoring and management
•During the last inspection in December 2017, we identified concerns about how people's individual needs were assessed, and in respect of the safety of the environment. We found continued concerns during this inspection.
•People did not always have risk assessments in place regarding aspects of their health and social care. For example, risk assessments were not in place to support staff with providing care and support to people with chronic health conditions. This included diabetes, the administration of blood thinning medicines, those at risk of seizures, chocking, skin care and where behaviour may place a person, or others, at risk. This meant associated risks may not always be mitigated as required.
•One person was being placed at risk of skin damage because they were moved at night without the required moving and handling equipment.
•People's risk of malnutrition was not being managed safely. People's records held a multi-universal screening tool (MUST) assessment. 'MUST' is a five-step screening tool to identify adults, who are malnourished or at risk of malnutrition (undernutrition). However, the weight monitoring and the steps identified in the MUST to manage people's risks were not completed.
•People at risk of falling did not have a risk assessment to measure and monitor their risk of falling and staff moved people's walking frames away from them when they were sat in the lounges and/or dining room. Therefore, we saw people had to stretch forward for their frame rather than having their frame to hand if they wanted to go to the toilet.
•People were not routinely given or assessed if they needed a means to call staff for support.
•Environmental checks were not taking place to ensure the safety of people's environment. For example, checks to ensure water accessible by people was running no hotter than 45 degrees centigrade, and the safety of window restrictors, were not taking place.
•People were being placed at risk of falling due to an access/exit from the conservatory which had not been assessed to ensure it was non-slip and no handrails were in place.
•At the last inspection we raised concerns about people's access to the kitchen. We were told that a lock would be fitted. However, we found the kitchen continued to have open access. We observed one person, who did not have the mental capacity to understand kitchen risks, walk freely in and out. There was no environmental risk assessment in place. Sharp objects and scalding water were freely available. During our inspection, we asked the provider to take action to fit a lock.
•People who did not have the mental capacity to understand risk, were able to feely access the laundry area. This placed people at risk from accessing hot surfaces, of cross contamination and chemicals. During our inspection, we asked the provider to take action to fit a lock.
•People were not always protected from the providers fire procedures. Weekly checks of the alarm system, emergency lighting and door closures had not taken place since October 2018. All staff had not received up to date training in line with the providers policy. We advised the fire service of our findings.

Preventing and controlling infection
•We observed on the first day of the inspection that staff were using the same personal protection equipment (PPE) from person to person. This did not protect people from the unnecessary spread of infections and was not in line with infection control best practice guidelines, set out by the National Clinical Institute for Excellence (NICE).
•People were at risk of cross infection as soiled laundry was being placed on the floor. We asked the provider to take immediate to address this.
•There were no cleaning schedules in place for laundry equipment.

Learning lessons when things go wrong
•As demonstrated in respect of medicines and infection control, the provider did not demonstrate they were learning from events.

Not ensuring people's medicines was safe, risks were identified and mitigated and ensuring good infection control are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The service was clean and free of adverse odours. Equipment in the form of hand washing, aprons and disposable gloves were available to staff. One staff member was observed to use hand gel. One person said, "It's always clean." Another person receiving care in their own home said, "They always wear gloves and aprons."
•Personal emergency evacuation plans (PEEPs) were in place for people living in the home.

Recruitment
•Staff recruitment processes lacked structure and were not safe. There was no system of ensuring all checks and references were in place before a new staff member started work. All three personnel files were incomplete in the information held and did not contain employment histories and references from previous employers.

Not ensuring the safe recruitment of staff is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing
•People told us they felt there was enough staff to meet their needs. People living in the care home and those receiving personal care in their own homes told us they never had to wait to have their needs met.
•At our last inspection in December 2017 we recommended the provider implemented a staffing assessment tool to help demonstrate they had sufficient numbers of staff on duty, to meet people's needs safely. We found this recommendation had not been acted on as there was no evidence of how staffing was being organised in respect of people's needs. For example, overnight the residential home had one sleeping night worker who slept approximately from 1am to 6am. Staff told us they slept when everyone was settled, and tasks were completed. We spoke with the provider about this as one person who needed two carers to change their position at night safely. They advised they would review the suitability of a having a sleeping night worker. In addition, staff commented weekends could be a problem in the home when two care staff may be on duty in the day rather than three.
•We found there were enough staff on duty during the inspection and people in the community had their needs met. People living in the care home told us, "There are enough staff, well I think so" and another, "I think there are enough staff. They're fairly quick to answer the bell."
•People receiving care in their own home, commented, "They arrive on time in the morning." A relative said, "Staff are always available – we decided on a group of carers rather than just one – it's safer. You always have back up then."

Systems and processes to safeguard people from the risk of abuse
•Staffs knowledge about safeguarding procedures was limited.
•People living in the residential home told us they felt safe; one said, "It's very safe here – they couldn't do better" and a relative said, "I know she's safe here."
•People living in their own homes told us, "I would tell them if I was worried about anything or didn't like something."

Requires Improvement

Is the service effective?

Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance
•We checked whether the service was working within the principles of the Mental Capacity Act 2005, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). (DoLS do not apply to the domiciliary/care in people's own home).
•The registered manager and staff did not have an understanding of the MCA. People's care records did not correctly detail people's capacity.
•Mental capacity assessments which had been undertaken by the provider were not completed in line with the principles of the MCA and/ or always an accurate reflection of a person's MCA.
•DoLS applications had not always been submitted to the local authority as required, and people's care plans were not always reflective of the correspondence held between the local authority and the service. This meant people's human rights may not be protected.

Not ensuring consent in line with the MCA is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•We observed people were supported to have choice and time to consent to their care.
•People and relatives of those living in the residential home told us they were fully involved as needed. One relative told us, "Both me and another relative are fully involved in decisions and they keep us informed about everything."
•People living in their own homes commented, "I decide about my care. I only have one carer a day now."

Staff support: induction, training, skills and experience
•Staff did not have the training, skill, supervision and competency to meet people's needs effectively.
•We were told the service had an induction in place. However, from the records provided to us, we could not establish what was covered in the induction as paperwork was incomplete or blank. Staff told us the Care Certificate (a national health and social care induction) was being used for new staff.
•Staff were not being trained to meet people's specific needs. For example, staff had no training in respect of caring for people with a diagnosis of diabetes, stoma care, seizures, and catheter care. Training in respect of

people living with dementia needed updating or implementing for newer staff. When we spoke with staff, there was variable competency demonstrated.
•Staff prepared food and drinks for people, however food safety was not included in the mandatory training of care staff.
•Staff did not receive supervision, appraisals or have their ongoing competency checked to help ensure the delivered safe and effective care.
•We were told by the registered manager/provider that a lot of training had been booked over the coming weeks.

Not ensuring staff are suitably trained, supervised and appraised is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Overall people felt staff could meet their needs. Comments included, "Some staff understand my needs – it depends who's on, some are better than others", and "They know what I want. [Carers' names] is the friendliest. They do a good job."

Staff working with other agencies to provide consistent, effective, timely care
•People's records noted involvement with the Parkinson's Nurse, stoma nurse, district nurse team and GPs. However, when professional advice was sought from health and social care professionals, this was not recorded in people's care records to enable care staff to follow the advice given.
•We found there to be a lack of recording in respect of the support and management of people at risk of constipation. We referred this concern to the local authority safeguarding team, the GP and the district nurse service to ensure people's needs are met.
•People's care plans contained historical information and were not a contemporaneous record of their care. Because of this, staff told us, us they did not read the care plans as they found them difficult to follow and to find important information, so they relied on verbal communication and the shift handovers.

Not ensuring safe communication about people's health needs is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The district nurse and GP felt the service kept in touch with them.
•The registered manager/provider involved the Speech and Language Team (SALT) and, older peoples' mental health services when needed.

Supporting people to live healthier lives, access healthcare services and support
•The GP dedicated to the residential home attended every Monday to review people's non-urgent health needs.
•People living in the residential home told us, "If I need to see doctor or other people like an optician you just ask the manager and they bring them in." Another said, "The doctor came and checked on me last week."
•One person receiving care in their own home said, "My daughter would call the doctor if I needed one, but the carers sometimes suggest I see the nurse" and a relative said, "They definitely meet his needs – they let us know if there are any health worries. With the catheter, [carer's name] came on her day off to sort it out."
•We spoke with the podiatrist, they told us they felt the staff knew people's up to date needs in respect of their feet and would follow advice they gave.

Adapting service, design, decoration to meet people's needs
•The upper floor was reachable via a stair lift.
•At our last inspection in December 2017, we recommended the provider reviewed the environment, by taking account of best practice and dementia research. We found that this had not been followed. For

example, there was no use of dementia friendly signs being used. This would support people living with dementia and who had short-term memory needs to negotiate their environment and be independent in meeting their needs.

We recommend the provider reviews the environment, taking into account of best practice and dementia research.

Supporting people to eat and drink enough to maintain a balanced diet
•We received many positive comments in respect of the food; it's quality, choices and availability. The kitchen staff had worked at the service for some time and ensured they were kept up to date of people's needs. One person described the kitchen staff as "Amazing".
•People living in the residential home said, "Oh the food – talk about spoilt! I love my food. We get a choice every day. We have a cooked breakfast one day a week, on a Thursday." A relative said, "I can't fault the food. On a Saturday she has an omelette and there is quite a standing joke about it."
•Relatives of people receiving care at home were complimentary about the supported provided to those people who needed help with eating and drinking. Comments included, "We maintain a healthy diet for them and on occasions he has meals delivered" and another, "She is well nourished – they do her poached egg on toast in the morning. They always leave a jug of water and leave her lunch and ask her what she wants for her tea."

Good

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence
•At our last inspection in December 2017, we found staff discussed peoples care needs within the hearing of others and people's care records were not being securely stored. At this inspection we found improvements had been made and people were respected, and records were held securely.
•We observed kind interactions between people and staff. People were positive about staff and their care.
•On day three of the inspection we observed a large number of staff came out of their training during lunch time and went in to the conservatory where a number of people were sitting. There was no seeking the permission of the people as to whether they minded staff coming in. There was an assumption that this was alright. When the inspector commented, they received an apology, but no one apologised to the people whose home it was.
•Comments we received from people living in the residential home included, "The staff really care; the staff are very polite and friendly – we have a good laugh"; "They always knock before they come into my room and keep the door shut when I'm having personal care" and, "The staff are very nice and polite".
•A relative said, "They do maintain her dignity and privacy and don't discuss things in front of others. They always take me somewhere else to talk."
•People receiving care in their own home said, "I look forward to their visits – someone to talk to. They're very kind and caring" and, "I get along with all of them – they're as good as gold."
•A relative said, "When she gets depressed the carers will take time out to sit and chat with her for quite a while to help her." Another said, "I was involved in planning for their care and support and I do think the staff respect her privacy and dignity."

Ensuring people are well treated and supported; respecting equality and diversity
•People were supported to build and maintain friendships.
•People could develop personal, loving relationships with others.
•Religious services were held that people could attend. People were supported to have their chosen faith leader to come and see then as they desired.

Supporting people to express their views and be involved in making decisions about their care
•People told us they felt they were in control of their care. Relatives told us they were consulted and kept up to date as needed.
•People living in the residential home said, "The staff listen to me – they chat with me a lot"; "I make all my own decisions and stay up for as long as I like" and, "I go to bed and get up when I choose and dress how I like."
•A person receiving care in their own home said, "We discuss my needs and they know I have difficulties getting up from a chair. A frame arrived last week for my toilet and makes life a lot better".

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•People's care records were not updated when their needs changed, but updated according to the providers schedule, which meant records did not always contain important information about people. For example, staff told us how they would identify that one person was having a seizure, but this was not recorded to ensure the continuity and safety of a person's care.
•When external advice was given it was not always recorded, or it was presented in a way that made this information very difficult to find. Information about how to meet people's health needs in respect of their diabetes, stoma care, seizures and behaviour that may challenge, for example, were hidden amongst a lot of other information.

Not having the systems in place in respect of people's care records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The provider was not meeting the requirements of the Accessible Information Standard (AIS). This is a legal requirement to ensure people with a disability or sensory loss can access and understand information they are given. Each person's care plan did not always include a section about their individual communication needs to help ensure consistent care and support.
•Documents, such as care plans and polices were not always available in a different format, such as large print, or pictorial format.

We recommend the provider researches and implements the Accessible Information Standard (AIS) within the service.

•People were looked after by a stable and consistent staff group. Only two staff new had been employed in the last 12 months. There were always staff around who knew what people liked and disliked. Staff worked as a team and respected that some staff could relate to certain people better than others.
•People and relatives told us they were happy with their care and felt the staff were responsive to their needs. People's records showed when their care plan had been discussed with them. One person said, "I do get involved with decisions [about my care] and with my daughter. They get in touch with her if they need to."

Improving care quality in response to complaints or concerns
•People and relatives told us they felt they would complain if needed.
•There was no system in place to record and demonstrate people's complaints and concerns had been met. This also meant learning could not take place from the issues raised to help improve people's experience of the service.

•The provider's information return (PIR) stated one complaint had been received in the last 12 months but the details of it was not available for us to read.

End of life care and support
•The district nurse told us they felt the service was good at meeting people's needs at their end of life and that they would recommend the service for this purpose.
•People were supported to die with dignity and pain free.
•People's records contained their treatment and escalation plan (TEPs) which described their wishes should they become unwell, and detailed if people had a chosen funeral plan in place. However, people's care records had not been updated to describe their end of their life care in order to meet their changing needs.

Inadequate

Is the service well-led?

Our findings

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

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

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

•The management team were made up of a registered manager who is also the provider, a manager and a deputy manager.

•There was a lack of leadership and governance because all the management team were working on the floor delivering care. No one was taking a strategic oversight or making sure the various other tasks required by managers were taking place.

•There was also a lack of organisation between the three leaders and assumptions on each other's behalf as to who was taking on which management task.

•The provider had not ensured incident reporting and recording systems were in place. The provider did not understand their full responsibility of what they are required to notify us in respect of the legal requirements. For one person, this meant there was no oversight for two incidents where they were found to be unsafe in the community and police were involved.

Not ensuring the Commission is notified as required is a breach of Regulation 18 of the Care Quality Commission Regulations 2009 (Part 4).

•Following our inspection in December 2017, the registered manager/provider had failed to ensure the concerns identified and recommendations made at the time were addressed.

•Some areas of the inspection that were compliant last time were no longer meeting the requirements of the Health and Social Care Act (2008).

•The registered manager/provider had not ensured systems were in place to oversee the quality and safety of the service. For example, audits of the services provided were not carried out and maintenance checks had ceased in 2018 putting people at risk of scalding, falls from height, from heated surfaces and in the event of a fire.

•Systems to oversee the monitor of staff training, supervision, appraisal and competency had not been established.

•There were no systems in place to ensure people's capacity was assessed and care was in line with the Mental Capacity Act 2005.

•There was no system of oversight to ensure staff were recruited safely and that all checks were in place as required.

•The system for ensuring people's records were contemporaneous and contained essential details was not effective. Staff kept records of what people had eaten and drank. However, there was no system operating to audit and check these records to ensure any changing needs could be picked up quickly.

•People's risk of, and incidents of falling, were not audited to see if any lessons could be learnt.
•There was no audit of infection control currently taking place and infection training was not up to date for all staff.
•The service experienced an outbreak of diarrhoea and vomiting in the week commencing 18 March 2019. We spoke with the registered manager/provider about whether learning had been sought to identify a possible cause to keep people safer in the future. This had not taken place to date. The Department of Health (DoH) recommend care homes complete an analysis when there have been occurrences of infection to identify and understand any improvements to care or to reduce the risk of recurrence. We had advised the provider of this on 19 March 2019.
•There was not a system for medicines incident reporting which meant errors were not identified, investigated and/or learnt from. The providers information return (PIR) stated there had been 12 medicine errors in the last 12 months, with no analysis and learning

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 manager/provider had not kept up to date with current research, guidance and initiatives in respect of people's care and the management of a registered care organisation.
•Recommendations made by the Care Quality Commission, in respect of dementia care, staffing tools and Accessible Information Standard had not been acted up.
•The system for ensuring medicine administration was not in line with best practice had not protected people from associated risks.
•National initiatives around improving the care of people living with diabetes care and end of life care had not been acted on.
•The provider was not aware of the current guidance in respect of infection control and health and safety in care homes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•There were some systems in place to seek the views of people using the service. For example, people told us they received questionnaires to ask how they felt about the service. We asked for the outcome of the most recent questionnaire, but the provider told us they could not find the information.
•The provider told us there had been a considerable time-lapse between residents' meetings from 2018. The most recent meeting provided people with the opportunity to give their views and for the registered manager/provider to share information.
•Staff told us their feedback to the manager was not always received positively.

Continuous learning and improving care
•The registered manager/provider had not established systems to learn from events and therefore improve the care of people.

Not having appropriate systems of leadership and governance in place in is an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
•The service was not currently accredited or working with other agencies to support them in the role of governance and leadership, to help ensure the service delivery was of a high standard.
•The registered manager/provider were unable to demonstrate they or their staff developed and maintained links with other organisations.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to meet the condition to ensure people are of good character.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission without delay about two incidents involving a person being at risk in the community and had involved the police.

The enforcement action we took:

We imposed a condition on the provider's registration. Conditions are specific actions or tasks for a provider to complete and report to us on their progress. .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of people was not always provided in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

We imposed a condition on the provider's registration. Conditions are specific actions or tasks for a provider to complete and report to us on their progress.

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 in respect of: Assessing the risks to the health and safety of people. All that was reasonably practicable was not being done to keep people safe from their risks. The premises used by people was not assured to be safe. The equipment used by people was not assured to

	be safe. Medicines were not assured to be proper and safe. Infection control was not being assessed to prevent, detect and control the spread of infections.

The enforcement action we took:

We imposed a condition on the provider's registration. Conditions are specific actions or tasks for a provider to complete and report to us on their progress.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and/or operated to: Assess, monitor and improve the quality of the service. Assess, monitor and mitigate the risk to the health, safety and welfare of people. Ensure records were complete and contemporaneous; including a record of care and treatment provided to people. Seeking and evaluating feedback to constantly evaluate and improve the service. Evaluating and improving their practice.

The enforcement action we took:

We imposed a condition on the provider's registration. Conditions are specific actions or tasks for a provider to complete and report to us on their progress.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate training, professional development, supervision and appraisal necessary to enable them to carry out the duties they were employed to do.

The enforcement action we took:

We imposed a condition on the provider's registration. Conditions are specific actions or tasks for a provider to complete and report to us on their progress.