Le Flamboyant Limited

Sunrise Care Home

Inspection report

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Tel: 01933650794

Date of inspection visit:
02 September 2021

Date of publication:
26 October 2021

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
Sunrise Care Home is a residential care home registered to provide personal care for up to 20 older people, some of whom are living with dementia. At the time of the inspection 15 people were living in the home.

People's experience of using this service and what we found
The provider continued to fail to have sufficient systems and oversight to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. The provider had not made enough improvement since the last inspection to ensure people were protected from risks associated with the safety and management of fire, water, food, substances that could be hazardous to health (COSHH), medicines and environmental risks. People living with dementia were exposed to unnecessary risks.

The provider failed to ensure staff had access to and follow current government guidelines for the prevention and control of infection. This placed people and staff at continual risk of being exposed to and acquiring infections including COVID-19.

There were not enough staff employed to meet people's needs. The manager and care staff carried out multiple roles; there were not enough staff to provide personal care. People did not always receive their personal care as planned or have staff available to them to administer their medicines as prescribed. The provider failed to ensure staff followed national guidance when administering medicines.

The provider failed to learn from safeguarding, complaints, accident or incidents to use these experiences to improve the service.

Most staff had received training; new staff required further training and checks on their competence to ensure they were following the provider's policies and procedures.

People were supported to maintain a balanced diet. However, not all risks had been mitigated to prevent the risk of choking.

Improvements had been made to the decoration and maintenance of the home. Flooring had been replaced in the communal areas and bedrooms and bathrooms had been refurbished. More improvements were required to create an environment which was more dementia friendly.

People's risk assessments and care plans had been recently updated. Staff had the information they needed to mitigate the known risks. Staff received a comprehensive handover about people's current needs.

Staff knew how to recognise the signs of abuse and who to report their concerns to. Staff had raised their concerns with the manager who raised safeguarding alerts appropriately.

Staff were skilled in taking clinical observations and referring people to medical services when people's conditions deteriorated.

The provider was not meeting the requirements of the Accessible Information Standard. People living with dementia did not have access to information in mediums they could access.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for this service was Inadequate (published 20 April 2021).

Why we inspected
The inspection was prompted in part due to concerns received about the staffing levels, safety and managerial oversight demonstrated in the monthly action plans to the commission. A decision was made for us to inspect and examine those risks.

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.

At the last three inspections the provider was in breach of regulations relating to safe care and treatment and managerial oversight. We imposed conditions on their registration which required them to provide monthly action plans to show what they were doing to implement and sustain improvements.
At this inspection enough improvement had not been made and the provider was still in breach of regulations. We have identified three breaches in relation to safe care and treatment, staffing and management oversight.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sunrise Care Home on our website at www.cqc.org.uk.

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

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.

This service has been in Special Measures since 24 March 2021. During this inspection the provider did not demonstrate that improvements have been made. The service remains rated as inadequate overall. Therefore, this service remains 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.

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, 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 following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Sunrise Care 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. 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.

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

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Sunrise Care Home 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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 three people who used the service about their experience of the care provided. We spoke with one health professional who regularly visited the service. We spoke with five members of staff including the manager, chef and care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 15 people's care records and multiple medication records. We looked at two staff files and one agency staff file in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at health and safety data, accidents and incidents and infection prevention information.

Inadequate

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last three inspections the provider had failed to robustly assess and mitigate the risks relating to the health, safety and welfare of people, this included infection control. This was a continued breach of regulation 12 (2) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

Preventing and controlling infection

- The provider failed to implement and embed a suitable policy and procedure for the prevention and control of infection. This meant staff did not have access to the current government guidelines to prevent the spread of infections including COVID-19.
- People were not protected from the risks of acquiring infections such as COVID-19 as staff did not follow the current government guidelines to isolate people on return from hospital. Two people had returned from hospital on August 2021; care notes showed, and staff told us they had both regularly taken part in activities with others in the lounge in the two weeks after they returned from hospital. This put other people at a higher risk of contracting COVID-19.
- Staff failed to follow government guidelines for the early detection of COVID-19 symptoms. Staff failed to take people's temperatures twice a day. This placed people at risk of not being identified as having symptoms of COVID-19.
- Staff did not follow current government guidelines to ensure they did not have symptoms of COVID-19 before each shift. Staff were required to take and record their own temperatures, however, in August 63% of day staff and 93% of night staff did not take their temperatures as required. This placed staff at risk of not being identified as having symptoms of COVID-19.
- Staff failed to follow current government guidelines to clean high touch areas twice a day to prevent the risk of the spread of infections including COVID-19. Cleaning records showed for the period between 26 April to 1 September 2021 staff failed to clean high touch areas twice a day for 26 days. This placed people, staff and visitors at increased risk of acquiring infections including COVID-19.
- People did not always receive their personal care as planned. The care records for eight service users showed staff had not carried out personal care daily for five to seven days between 23 August and 1 September 2021; we observed people looked unkempt. People did not have access to liquid soap in communal bathrooms to wash their hands. We observed a bar of soap was in use in the communal bathroom. This placed people at risk of cross infection.

Assessing risk, safety monitoring and management;

● People were not protected from the risks associated with fire. Staff had not checked all the fire doors and all the emergency fire door closures over a period of six months. Staff had not carried out quarterly essential checks such as checking storage of flammable materials, loading of electrical sockets and outstanding electrical repairs. There was a risk the fire doors were not providing adequate fire safety as they have not been checked for their integrity. People were not protected from the risks of the spread of fire as the kitchen and laundry doors were wedged open.
● People living with dementia had ready access to the kitchen and laundry rooms, as these doors were wedged open, and the laundry room did not have the facility to be locked. This placed people at risk of accessing industrial electrical equipment, hot surfaces such as the electric hob, hot urn, oven and sharp knives.
● People were not protected from the risks associated with substances that could be harmful to health (COSHH). People had access to the kitchen, laundry, COSHH cupboard and rooms that were used for storage of COSHH items. People living with dementia had access to unlocked cabinets in their rooms containing teeth cleaning tablets and razors.
● People were not protected from the risks of scalding. The provider failed to ensure water temperatures were within a safe range as these were not checked and adjusted in showers and bathrooms regularly. People were at risk of scalding as they had access to areas where very hot water was used such as the laundry and the kitchen.
● People were at risk of infection such as Legionella as the provider failed to follow health and safety guidelines for the safe management of water. The provider did not check the cold water was stored at the right temperature, regularly flush taps or showers that were seldom in use or cleaned and descaled shower heads.
● People were at risk of food poisoning as staff failed to record and label food when it had been stored in a freezer and defrosted. On the day of inspection, the chef cooked meat that had an expiry date seven days before the inspection. Although the chef and the manager told us the meat was safe to eat as it had been frozen, there were no records to show this. We observed frozen fish being stored in a freezer compartment in the fridge that was not monitored for its' temperature, or any records when the fish had been stored there.

Using medicines safely;
● Medicines were not managed safely. The provider failed to ensure staff followed the National Institute for Health and Care Excellence (NICE) pathway for Care home staff administering medicines. Staff failed to accurately record the name of medicines, the dose or the dates they had been prescribed and administered. Staff failed to keep accurate records of controlled medicines in the controlled medicines register.
● Staff failed to accurately record the stock levels of medicines, which meant it was unclear if people had received all their medicines as prescribed. Records showed people had either too little or too much medicines left in stock, even though staff had signed to say medicines had been administered as prescribed.
● Staff failed to administer medicines as prescribed. For example, one medicine was due the day after the day of inspection, but the records showed staff had given it on the day of inspection. Another person did not receive their weekly medicine as prescribed.
● People did not always receive their topical medicines as prescribed. Staff recorded when they had administered people's creams, these records showed people's topical creams were not given regularly or consistently.
● Medicines were not always stored safely. One tablet was in a pot in a cupboard. There was no information to say what the tablet was, who it was prescribed for or when it had been placed there.

The provider failed to assess the risks to the health and safety and doing all that was reasonably practicable to mitigate any such risks; Ensure proper and safe management of medicines; Assess, prevent and control the spread of infections. This placed people at risk of harm. This was a breach of regulation 12 (2) (a) (b) (g)

and (h) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's risk assessments and care plans had been recently updated. Staff had the information they needed to mitigate the known risks.
● Staff received a comprehensive handover about people's current needs.

Staffing and recruitment
● The provider failed to have enough staff employed to meet people's needs. Although the provider used an agency to supplement staffing levels, only one member of agency staff was used. Of the 31 days of rotas we reviewed in August and September 2021, the provider failed to provide a full complement of staff for 27 days.
● The manager and care staff carried out multiple roles such as cleaning and cooking. However, there were not enough staff to provide personal care, prepare food and carry out the cleaning. This meant every day some managerial oversight, cleaning tasks or personal care was not completed. This placed people at risk of not receiving their planned care.
● The provider failed to always deploy staff suitably qualified to administer medicines. The training records showed only senior staff and the manager were trained to administer medicines. The rotas showed four night shifts and three day shifts in August 2021 there were no senior staff or manager on duty. This meant people were at risk of not receiving their medicines as prescribed.
● The provider did not ensure their recruitment procedures were followed. For example, one member of staff did not verify their reasons for leaving previous jobs with vulnerable adults. Two members of staff did not have the required two references.

The provider failed to have sufficient numbers of suitably qualified, competent, skilled and experienced persons employed and deployed to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (1) (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a system and process in place to ensure Disclosure and Barring Service (DBS) checks were completed for all staff prior to them working with people. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Staff had access to a safeguarding policy, however, it did not include all the information staff required to contact the local authority safeguarding team.
● Staff demonstrated they knew how to recognise the signs of abuse and who to report their concerns to. Staff had raised their concerns with the manager.
● The manager had raised safeguarding alerts appropriately and worked with social workers to investigate concerns.

Learning lessons when things go wrong
● Accident and incident forms were available for staff completion and staff understood the importance of recording accidents and incidents. There had not been any incidents between February and July 2021, however, there had been three incidents in August which had yet to be analysed for themes and learning.
● There was no evidence of sharing and learning from safeguarding incidents. This meant staff did not get the opportunity to look at and improve their practice to improve people's care and safety.

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.

At the inspection on 7 August 2019 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.

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

- Staff were aware of people's dietary needs; some people had special diets such as soft foods.
- One person had refused their special diet. Their care plan stated staff were to monitor them when they ate. Staff were to provide foods which the person could make safe, for example, they could have biscuits which they could dip in their tea themselves food such as boiled potatoes they could mash themselves. However, we observed the person was eating alone in their room with their door closed, and not visible to staff, placing them at increased risk of choking. We discussed this with the manager who stated they would ensure staff would observe them to eat.
- People were assessed for their risk of losing weight. Where people refused their meals, high protein drinks were offered instead. People's weight was monitored regularly; where people had lost weight, they had been referred to their GP and health professionals for advice.
- People's care notes showed people were offered balanced meals, fruit and snacks.

Staff support: induction, training, skills and experience

- Most staff had received on-line training that provided them with the knowledge they required to meet people's needs, however, their on-going compliance with policies and procedures had not been checked. For example, records show staff had their competencies about managing substances hazardous to health (COSHH) been checked in May 2021, however, during the inspection none of the staff were following the policies relating to COSHH items.
- The training records showed new staff who commenced employment in the first two weeks of August 2021 had not received their training in moving and handling, fire safety or infection control. This placed people at risk of not receiving their care safely.
- New staff shadowed staff for two days as part of their induction to get to know people and how to provide their care.

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

- Improvements had been made to the decoration and maintenance of the home. Flooring had been replaced in the communal areas, and bedrooms and bathrooms had been refurbished.
- Several people living in the service were living with dementia, but the environment was not always dementia friendly. At our inspection in August 2019 we discussed with the provider the measures they could take to make the service a more dementia friendly environment in relation to signage to support people to live well with dementia. These measures had not been taken.
- The manager carried out regular checks of window restrictors, hoists and wheelchairs. However, there

were two wheelchairs in use and the records showed only one had been checked. It was not clear which wheelchair had been checked.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People and their relatives were involved in identifying people's care needs and choices.
● People's risks were assessed using evidence-based risk tools such as the Waterlow pressure ulcer risk assessment tool.
● Assessments were comprehensive and reflective of the Equality Act, considering people's individual needs, which included their age and disability.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● District nurses visited the home twice a day to monitor and give injections to people living with diabetes. One district nurse told us, "I am sometimes asked to look at people's pressure areas, when I do, I do a full check."
● Staff were trained to carry out clinical observations and knew when to contact medical teams. We saw examples in records where staff had identified people's deteriorating health and sought emergency treatment in a timely way.

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 authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider was following the principles of the MCA. People had been assessed for their mental capacity to understand the restrictions and procedures required during the COVID-19 pandemic; the outcomes of best interest meetings decisions had been recorded.
● The provider had submitted DOLS applications appropriately.

Requires Improvement

Is the service caring?

Our findings

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

At the inspection on 7 August 2019 this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; Respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- The provider had not ensured people had been treated with respect as they had not implemented or embedded systems for staff to follow infection control, fire, water or food safety guidelines to keep people safe or provide a clean environment.
- Staff appeared very busy and did not have time to talk to people. Where staff did interact with people it was whilst they provided care, food or drink. For example, we observed one person calling out requiring reassurance, but staff ignored them. They were becoming distressed about having butter on their toast, but staff did not acknowledge this; the person did not eat the toast.
- People's rooms were not always kept clean. Where people's rooms required cleaning regularly due to their behaviours, staff had not been allocated to ensure the rooms remained hygienic.
- People living with dementia had not had the opportunity to express their views about the service.
- One district nurse told us, "Staff are mostly kind and speak nicely to people."
- We observed staff who knew people well were confident in speaking with people and appeared to have a good relationship.

Respecting and promoting people's privacy, dignity and independence

- People chose when they got up and went to bed. Staff supported people who got tired in the day to rest, and those who got up early to have an early breakfast.
- People's records showed their likes and dislikes, which staff were aware of.
- Staff ensured people received their personal care in private.

Requires Improvement

Is the service responsive?

Our findings

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

At the inspection on 7 August 2019 this key question was rated as requires improvement. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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's relatives visited the home; their temperature was taken on arrival to the home to ensure they did not have any COVID-19 symptoms. However, there were no records of being asked for results of lateral flow tests. We discussed this with the manager who stated all the relevant checks of visitors were made.
- One person went out for the day with their relative during the inspection; staff had ensured they were prepared for their trip.
- Staff took time out in the afternoon to carry out group activities such as sing-a-longs, bingo, quizzes and crafts. There was no specific staff employed to develop the activities to meet individual's needs or to be carried out at other times.
- People who had hobbies and interests continued to pursue these. One person was proud to show us their collection of models.

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

- People's care plans guided staff how to meet people's needs and preferences. However, due to the low numbers of staff people received care only when staff were available. This meant staff carried out people's care in a task orientated way, not in a personalised way. This meant the care provided did not always meet people's preferred timescales.
- People did not always receive their planned care; their records showed gaps of between five to seven days where personal and oral care was not provided or records completed.

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 provider was not meeting the requirements of the Accessible Information Standard. People living with dementia did not have access to information in a way they could access.

Improving care quality in response to complaints or concerns

- People had information in their rooms which explained the complaints procedure. There was no easy read or procedure in place to gather information about people's concern if they were unable to read or express themselves in writing.

● The manager had responded to complaints in line with the provider's policy, however, one issue that had been raised about cleanliness was still observed to be ongoing at our inspection.

End of life care and support

● People's end of life care and support had not been documented as having been discussed with them or their relatives. This meant there was a risk people would not receive end of life care that met their individual needs or reflect what was important to them.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question remains inadequate. 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; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last two rated inspections, the provider had failed to ensure systems and processes were either in place or robust enough to ensure the safety and quality of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider failed to have sufficient systems and oversight to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. The provider had not made enough improvement since the last inspection to ensure people were protected from the risks associated with fire, water, substances hazardous to health, electrical equipment, hot surfaces and knives. This put people at risk of being exposed to fire, infected by contaminated water, scalded, burnt, or harmed from being continually exposed to these risks.
- The provider failed to ensure staff had access to current government guidelines for the prevention and control of infection. The provider did not have a system to identify staff were not following current government guidelines for COVID-19, which meant people and staff were continually being exposed to increased risk of acquiring COVID-19.
- The provider failed to have systems to identify when medicines were not being managed safely. This put people at risk of deteriorating health from not receiving their prescribed medicines.
- The provider failed to have a system to assess the level of staff required and available on duty to ensure there were enough staff to meet people's needs. This meant people did not always receive their personal care as planned or have staff available to them to administer their medicines as prescribed.
- The provider failed to have systems to assess, monitor and mitigate the risks associated with food management. Staff did not have information about how food had been stored. Staff had recorded the kitchen had been cleaned regularly, however, the kitchen was visibly dirty. This meant people were placed at risk of receiving food that had not been stored safely or prepared in an unclean environment.
- The provider failed to have sufficient systems in place to assess, monitor and improve the service. The provider failed to learn from safeguarding, complaints, accident or incidents to use these experiences to improve the service.

● The provider failed to store people's information securely. People's archived records were stored in three unoccupied bedrooms which could be accessed by any person in the home.

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

● There was no system in place to gather the views of people living with dementia who could not communicate in writing.
● We asked for the minutes of relatives' and staff meetings but these were not provided.

The provider failed to have systems and processes implemented and embedded to assess, monitor and improve the quality and safety of the service, and assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 17 (1) (a) (b) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not have a manager registered with the Care Quality Commission.
● The provider had understood the requirement to display their CQC rating and this was displayed in a communal area.
● Staff spoke highly of the manager, they all said they were supportive and approachable.

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

● The provider had a complaints policy and procedure in place which was also displayed in a communal area.
● The manager understood the need to be open and honest when things had gone wrong and remained open and transparent throughout the inspection. Records showed families were kept informed of any incidents or concerns with their relative.

Working in partnership with others

● The local authority quality improvements team had worked closely with the provider and management team to support with improvements. The provider had worked their way through an action plan, most of which had been completed by the end of June 2021. However, where actions had been completed, the new systems had not been fully embedded, which meant actions around fire, water and environmental safety had not been met at this inspection.

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 The provider failed to assess the risks to the health and safety and doing all that was reasonably practicable to mitigate any such risks; Ensure proper and safe management of medicines; Assess, prevent and control the spread of infections. This placed people at risk of harm.

The enforcement action we took:

We issued a notice to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems and processes implemented and embedded to assess, monitor and improve the quality and safety of the service, and assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

We issued a notice to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to have sufficient numbers of suitably qualified, competent, skilled and experienced persons employed and deployed to meet people's needs.

The enforcement action we took:

We issued a notice to cancel the registration.