Diamond Care (2000) Limited

New Redvers

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
New Redvers is a residential care home that provides personal care and support for up to 19 people with a learning disability, autism or who have complex needs associated with their mental health. At the time of the inspection there were 13 people living at the service.

People's experience of using this service and what we found
People told us they were happy and felt safe living at New Redvers and relatives did not raise any concerns about people's safety. We found the service was not operating in accordance with the regulations and best practice guidance. This meant people were at risk of not receiving care and support that promoted their wellbeing and protected them from harm.

The provider demonstrated a commitment to people living at the service and spoke passionately about providing good quality care. However, they did not have sufficient oversight of the service to ensure people received the care and support they needed.

Systems and processes to monitor the service were not being regularly undertaken or robustly completed. This meant they were ineffective, did not drive improvement and opportunities to learn from incidents, address poor performance and improve practice had been missed.

People were not always protected from the risk of avoidable harm. Where some risks had been identified, sufficient action had not been taken to mitigate those risks and keep people safe Key pieces of information relating to people's care and support needs were not always being recorded or followed up.

Some risks, such as those associated with people's environment, had not always been assessed or managed safely. For example, routine environmental checks in relation to water temperatures, window restriction and fire safety were not always being carried out.

People's medicines were not always managed safely.

Staffing levels were not always sufficient to meet people's needs and to keep them safe. Staff recruitment was not always safe as information received about potential new staff had not always been reviewed or followed up.

The service did not have an effective system in place for recording what training staff had received. This meant the provider could not be assured that staff had the necessary skills to carry out their roles. Staff told us they felt supported. However, formal supervisions were not taking place.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for

granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture. The lack of effective leadership did not promote and ensure a positive and person-centred culture in the home were people were supported. This meant we could not be assured that people who use the service were able to live as full a life as possible and achieve the best possible outcomes that include control, choice and independence or that they were being supported to be the best version of themselves.

Whilst we did not find people were being disadvantaged, people were not supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible.

People were not always protected from the risk and spread of infection. Staff had not undertaken sufficient training and did not have the information they needed to ensure people were fully protected from the risks of infection.

People were encouraged to share their views through regular house meetings and relatives felt comfortable raising concerns and were confident these would be acted on.

The provider had been working with representatives from the local authority safeguarding and quality teams following concerns identified to make improvements needed.

Throughout the inspection we found the provider and nominated individual to be open and responsive to our feedback. Whilst they had not been fully aware of all the concerns we identified, they were aware of the need to improve and keen to make those improvements.

Following the inspection, the provider informed the Commission they had appointed a management consultancy service to manage the home on a day to day basis and support the necessary improvements.

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

Rating at last inspection
The last rating for this service was Good (published on 15 September 2018).

Why we inspected
We received concerns in relation to the management of people's medicines, health care needs, staffing levels, fire safety and the overall management of the service. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this

inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for New Redvers 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.

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, the need for consent, recruitment, staffing, notifications, and governance at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the 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 rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

We will meet with the provider 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 and continue to monitor the service through the information we receive until we return to visit as per our re-inspection programme.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

New Redvers

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
The inspection team consisted of one inspector on the first day, and two adult social care inspectors on the second day.

Service and service type
New Redvers is a care home. People in care homes receive accommodation and nursing or personal care. 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 at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

Notice of inspection
The inspection took place on 30 October and 04 November 2020, the first day was unannounced

What we did before the inspection
We reviewed information we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales.

We used all this information to plan the inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with nine people living at the home, seven staff members, the nominated individual and a director of Diamond Care (2000) Limited. The nominated individual is responsible for supervising the management of the service on behalf of the provider. To help us assess and understand how people's care needs were being met we reviewed four people's care records and observed staff interacting with people. We also reviewed a number of records relating to the running of the service. These included infection control, medication, environmental safety, staff training, and records associated with the provider's quality assurance systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We sought views from relatives and asked the local authority, who commissions care services from the home, for their views on the care and support provided. We received feedback from three relatives, four staff members and one healthcare professionals.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were not always protected from the risk of abuse and/or exploitation.
• Records for one person indicated that they may have potentially been placing themselves at the risk of abuse and/or exploitation by their actions. Action had not been taken to keep them safe.
• Staff had received training in safeguarding adults and were able to tell us the correct action to take if they suspected people were at risk of abuse and/or avoidable harm. However, staff had been aware of the risks we found but had not raised their concerns with the local authority. We discussed what we found with the nominated individual and asked them to make an immediate referral to the local authority's safeguarding team and the police for further follow-up/review, which they did. Action is now being taken.

The failure to effectively establish systems to investigate and report allegations of abuse placed people at an increased risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they felt safe living at the service and relatives we spoke with did not raise any concerns about people's safety.
• Other referrals had been made to the local authority's safeguarding team when appropriate.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• People were not always protected from the risk of avoidable harm as risks to people's health, safety and well-being had not always been identified, effectively assessed, managed or mitigated. For example, one person was being supported by staff with their personal care needs, such as, nutrition, mobility and skin care. There was no skin care risk assessment or care plan in place to guide staff on how to manage the risk and prevent damage to their skin. This put the person at increased risk of pressure damage.
• Where risks to people's health and welfare had been assessed, detailed guidance was not always available for staff to refer to. For example, where people were living with long term health conditions, such as, epilepsy or diabetes, records did not identify how they were to be supported to reduce any risks and maintain their safety.
• There was no risk assessment or care plan in place to guide staff on the safe management of people with urinary catheters.
•Staff told us that some people regularly displayed physically aggressive behaviour towards themselves, other people living at the service and staff. We found care records lacked detail about the circumstances that might lead to this behaviour and did not contain clear guidance for staff on how to manage the behaviour. This potentially placed the person, people and staff at risk of harm.
• Care plans had not been updated. For example, one person's care plan said they were walking around

independently, when they were now in fact, unable to move around independently at all.
• People had individual personal emergency evacuation plans (PEEP's) for emergency situations in place. These were generic and did not reflect people's individual needs.
• People were not always protected from the risk of harm as they were living in an environment that may not be safe. For example, routine environmental checks in relation to water temperatures, window restriction and Legionella were not being carried out.
• Where some risks had been identified, the provider could not demonstrate that action had been taken to mitigate those risks and keep people safe. For example, some of the people living at the service would not be safe if they left the service without support. We found three doors leading to the outside were not locked and had not been fitted with any device that would alert staff if someone left the building unattended. We discussed what we found with the nominated individual who assured us action would be taken to address this issue.
• We reviewed the home's fire safety precautions. Records showed a fire risk assessment had been completed in June 2020, which identified a number of actions which needed to be completed within a specified time frame. For example, regular fire safety checks were not being carried out and recorded. We discussed the fire risk assessment with the provider who gave us assurance that all actions had been completed. When we checked, we found some actions still needed to be addressed. For example, records showed routine checks on fire and premises safety were now taking place; however, it was unclear what staff were testing. And when tested staff still had difficulty opening the emergency fire exit door in the dining room. We have shared our concerns with Devon and Somerset Fire and Rescue Service.
• Records showed accidents and some incidents were being recorded. However, this information was not being analysed or reviewed. This meant the provider could not be assured that lessons had been learnt or sufficient action had been taken to keep people, staff and others safe from harm.

Whilst we found no evidence that people had been harmed. The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or managed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other risks were well managed.
• Some people were protected from risks associated with specific health care needs. Risk assessments guided staff to support people in a way that mitigated those risks and records showed specialist advice from healthcare professionals was sought where necessary and acted upon.

Using medicines safely
• People's medicines were not always managed safely.
• Medicine administration records (MAR) were not always accurate and there was no system in place to check the correct quantities of medicines were in stock. This meant the provider was unable to assure themselves that people were receiving their medicines as prescribed.
• Arrangements for storing medicines requiring extra security were not always safe. Although the service had suitable storage facilities for these medicines, these were not always being used.
• Medicines requiring refrigeration were not stored appropriately or securely and could be accessed by all staff.
• Some people were prescribed medicines to be administered 'when required' (PRN). There were no protocols in place to guide staff on the circumstances when these medicines should be offered or administered.
• Care plans did not contain specific information about people's medicines and their medical conditions. For example, care plans for people prescribed anticoagulants (to thin the blood) did not contain risk assessments or guidance for staff to follow if the person fell or developed unexplained bruising.

Whilst we found no evidence that people had been harmed, systems were either not in place or robust enough to demonstrate that risks arising from the management of people's medicines were being effectively mitigated or managed. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

• Staff told us they received medicines training, however the provider was unable to tell us when this training took place or able to locate evidence of staff competency checks being carried out. Following the inspection, the provider sent us a copy of the services training matrix which showed staff had received medicines training shortly before the inspection.

Preventing and controlling infection
• People were not always protected from the risk and spread of infection.
• Best practice guidance was not always followed in relation to infection control. For example, we observed some staff wearing their face masks below their nose.
• We were not assured that the provider was doing everything possible to prevent visitors from catching and spreading infections. For example, staff were not always ensuring visitors washed or used alcohol gel on their hands when they entered the service. Visitors contact details were not requested nor were they asked any health screening questions to ensure they were safe to enter the service.
• We were not assured that the providers arrangements for donning and doffing personal protective equipment (PPE) were sufficient to prevent cross-contamination.
• We were not assured that all staff had received sufficient training in infection control and/or the donning and doffing of PPE. The deputy manager told us the service did not check staffs' proficiency and competency with regards to donning and doffing PPE and did not conduct hand washing audits.
• Individual risk assessments had not been completed to identify and manage people at higher risk from COVID-19.
• People were not always supported or encouraged to socially distance whilst in communal areas of the home. Seating arrangements in some communal areas did not enable people to maintain the minimum distance from each other when sitting down, in line with Public Health England's current guidelines. This placed people at risk from the spread of Covid19.
• The service did not have policies or procedures in place to assist staff in the management of COVID-19. For example, contingency planning considering multiple factors which affect the operations of a care home, such as, how to manage staffing, consideration for emergency supplies and managing potential outbreaks.

Following the inspection, we shared our concerns with the local authority's infection prevention and control team. Whilst we found no evidence that people had been harmed. The provider had failed to ensure that risks relating to infection control were being effectively managed and this placed people at increased risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service was clean, and staff confirmed they had access to personal protective equipment such as masks, aprons, gloves and face shields.

Staffing
• Staffing levels were not planned or deployed in a way that met people's specific funding or health care needs to keep them safe.
• The nominated individual told us staff were employed in sufficient numbers to meet people's changing needs. This included dedicated 1:1 hours where these had been commissioned.
• We were given a copy of the rota and found it was not reflective of the hours identified by the provider.
• It was not possible to assess whether 1:1 funded hours were consistently being delivered or in line with

people's assessed needs. For example, some staff were unclear why some people had been funded additional 1:1 support. People's support plans did not contain any guidance for staff in relation to additional 1:1 funded hours.
• During the inspection we received information that the provider had failed to provide adequate night-time staff cover to meet people's needs safely. When asked, the provider was unaware that night staff cover had not been planned/delivered in line with their expectations. This information was shared with the local authority.

Whilst we found no evidence that people had been harmed, the provider could not evidence that sufficient numbers of staff were deployed appropriately to meet people's assessed needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment
• People were not always protected by safer recruitment procedures.
• We looked at the recruitment files for two members of staff. Whilst some recruitment checks had been carried out, information had not always been reviewed or followed up. For example, one of the records we looked at contained conflicting dates of employment compared with the reference provided.
• Records for a second staff member confirmed disclosure and barring checks (DBS) had been requested and obtained prior to them commencing work, however we found discrepancies in relation to dates and reference numbers contained within the staff's DBS documentation which meant the records did not match. We also found the provider had accepted character references from the applicant without checking their validity. This meant the provider was unable to demonstrate they had followed a thorough recruitment process in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to establish and operate effective recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Supporting people to live healthier lives, access healthcare services and support
• Staff told us people were encouraged to use a range of healthcare services and supported to attend appointments with their GP's and people had regular opportunities to see a dentist, or optician. However, we found staff did not always work together to ensure that people received consistent, timely, coordinated, person-centred care and support. For example, prior to the inspection we received information that one person had missed five separate appointments with their consultant. This was because staff had not managed the persons mail appropriately. This meant people did not always receive the support from professionals that they required in a timely way.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• It was not always clear from people's records if their needs had been fully assessed before they started using the service or were being regularly reviewed/updated following changes in their needs. For example, the nominated individual was unable to locate a copy of one person's needs assessment who had recently moved into the service. Some people's care records contained limited guidance for staff and were not being regularly reviewed or updated. Relatives we spoke with confirmed that they had not been asked to take part in care reviews. We understand this was partly due Covid 19.

Supporting people to eat and drink enough to maintain a balanced diet
• People were not always supported to maintain a healthy balanced diet which met their needs.
• Staff were not knowledgeable about how to support people who might have a historically difficult relationship with food.
• Where people were at risk of poor nutrition and hydration, staff told us plans were in place to monitor their needs closely. However, we found whilst staff were recording what one person ate and drank, no one was reviewing this information. Records showed this person was consistently losing weight. We discussed what we found with the deputy manager who told us that following a recent medical appointment concerns had been raised with regards how much this person was drinking. This information was not contained within this person's support plan nor had any guidance been provided for staff. We raised our concerns with the local authority who arranged for a dietician to review this person's nutritional and hydration needs.

Whilst we found no evidence that people had been harmed, the failure to provide safe care and treatment is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

• Other people's care records demonstrated that staff had made appropriate referrals to healthcare professionals when needed, documented the advice and arranged for follow up appointments as required.
• Some people's care records contained a 'Hospital Passport', which contained important information about them and their needs. This information went with the person when they went into hospital to help ensure their needs were understood and met.
• People told us they were supported and encouraged to be involved in choosing and planning their own meals. One person said, "We all sit down together and choose what we would like to eat." Another person said, "I like the meals here, the staff are good cooks."
• Support plans contained information about what people could do for themselves, their likes, dislikes as well as any allergies.
• People were freely able to access the kitchen with staff support and were people needed a specialised diet such as diabetic or gluten free, we saw this was provided.

Staff support: induction, training, skills and experience
• The service did not have an effective system in place for recording what training staff had received. This meant that neither the provider or nominated individual, could be assured that staff had the necessary skills to carry out their roles. For example, at the time of the inspection neither the provider nor the nominated individual were able to tell us if staff had up to date training in medicine administration, safeguarding, mental capacity, communication, person centred care, first aid or health and safety. The nominated individual told us that "some training" had taken place, but they have since found out the training was not accredited. Following the inspection, the provider sent us an up-to-date copy of their training matrix, this showed significant gaps in the training staff had received.
• Staff confirmed they attended training however two staff said they felt some of the courses had been of a poor quality and did not enhance their skills/knowledge. We found staff did not always recognise poor practice. For example, in relation to protecting people from harm, managing people's medicines, nutrition, MCA, infection control and health and safety.
• Staff gave us mixed feedback about the level of support they received. Some staff told us they felt supported while others said they did not. One member of staff said, "One of the managers is always available if you need to speak to them." Another member of staff said, "There was no point raising anything with the previous managers because nothing ever got done, you're better off going to the [nominated individual's name] or [providers name].
• None of the records we saw contained sufficient evidence to demonstrate that staff were receiving regular supervision, annual appraisals or the opportunity to debrief following incidents. We discussed what we found with the nominated individual who explained this had been due to changing roles within the previous management team. However, they had identified this was an area that needed improvement and had arranged for a manager from another service to carry out supervision with the staff team.

Whilst we found no evidence that people had been harmed. The failure to ensure staff had been provided with appropriate support, training and supervision potentially placed people and staff at an increased risk. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

• Whilst we saw staff obtaining people's consent, people's care records did not always show their consent and/or views had been sought in relation to decisions being made on their behalf or that people were being supported to have maximum choice and control of their lives. For example, where the service held or supported some people to manage their finances. There were no mental capacity assessments to show that people did not have capacity to manage their finances or that the decision to hold or limit their access to their monies had been made in a person's best interests. This indicated the service was not working in line with the principles of the MCA.

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

• Some restrictions had been placed on people's liberty to keep them safe, records indicated the provider had worked with the local authority to seek authorisation to ensure this was lawful. However, people's capacity to consent to care and support had not been assessed prior to applications being made to deprive people of their liberty.

Whilst we found no evidence that people had been placed at a disadvantage. The failure to assess people's capacity and record best interest decisions risked compromising people's rights. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• New Redvers is a large spacious building set over two floors with bathroom and toilet facilities. There was a large dining room where people could engage in activities such as arts and crafts a lounge were people could relax and watch television. There was a large patio area, were people would be able to sit or enjoy a BBQ and beyond the patio was a large garden, but this was difficult to access due to steep steps.
• People's bedrooms were personalised and furnished with items which were meaningful to them and celebrated their individual interests.
•The service was clean and maintained and the providers told us about their ongoing refurbishment plan which included a number of self-contained flats.

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 good. At this inspection this key question has now deteriorated to 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A manager had been appointed by the provider to oversee the running of the service in January 2020 and had left shortly before the inspection.

• The registered provider and nominated individual did not have sufficient oversight of the service to ensure people received the care and support they needed, that promoted their well-being and protected them from harm.

• The provider and nominated individual had been aware of concerns with the leadership and governance of the service since October 2019 and had developed a service improvement plan. We found insufficient action had been taken to check that improvements had been made and sustained. When asked, the provider told us they have been given verbal assurance that action had been completed but had not checked for themselves. The nominated individual told us that due to Covid 19 they had worked from home and had not been into the service since March 2020.

• Systems and processes to monitor the service were not being regularly undertaken or robustly completed. This meant they were ineffective, did not drive improvement and opportunities to learn from incidents, address poor performance and improve practice had been missed. For example, these included concerns with regards to care planning, management of risk, MCA, medicines and recruitment.

• The lack of effective leadership did not promote and ensure a positive and person-centred culture in the home

• A lack of robust auditing and managerial oversight meant the service did not pick up on concerns when they occurred, meaning they could not learn from them or improve care for people. For example, one person missed five medical appointments as the mail had not been opened for a number of weeks.

• People were not always protected from the risk of abuse or avoidable harm and systems were not in place to ensure the provider was made aware of all incidents. This meant they could not be assured that appropriate action had been taken to safeguard people or reduce the risk of reoccurrence.

• People were not protected from the risk of harm as they were living in an environment that may not be safe. Whilst some premises checks had been completed, risks to people's health and wellbeing had not always been identified, assessed or mitigated. For example, fire safety checks had not been carried out for a number of weeks as the member of staff responsible for fire safety had left and this task had not been reassigned to another staff member.

• Infection control audits were not taking place, this was particularly concerning due to the risks associated

with the coronavirus pandemic.
• The home did not have effective systems in place to assess or to monitor staff competence and skills to carry out the role required of them. This meant the provider could not be assured staff had the necessary skills and knowledge to meet people's assessed needs in a safe way.
• Records were not always accurate and had not always been updated to reflect changes in people's needs. For example, care plans and risk assessments were not being regularly reviewed/updated.
• Records were not stored securely. For example, records relating to people, staff and the provider had not been securely stored and could be accessed freely by all staff. This meant people's confidential information was not being stored in accordance with the General Data Protection Regulation 2018, (GDPR).
• Poor judgements/decision making potentially placed people at risk of harm. For example, in relation to protecting people from abuse, management of risk and the management of people's medicines.

Systems were either not in place or robust enough to demonstrate the service was being effectively managed and there was a clear lack of oversight. This potentially placed people at an increased risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider was aware of their responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm. However, the provider had not notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. This included the notification of safeguarding concerns.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

• We discussed what we found with the provider and nominated individual who acknowledged that some concerns had been a direct result of their lack of oversight of the service following the employment of the manager in January 2020.
• Throughout the inspection we found the provider and nominated individual to be open and responsive to our feedback. Whilst they had not been fully aware of all the concerns we identified, they were aware of the need to improve and keen to make the improvements needed. For example, on the second day of the inspection we saw evidence that the provider had appointed an independent consultant to undertake a full audit of the service and develop a service improvement plan. Following the inspection, the provider informed the Commission they had appointed a management consultancy service to manage the home on a day to day basis and make the necessary improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others: Continuous learning and improving care

• Although we were unable to view any formal feedback from people, people said they were happy and told us they were involved in some day-to-day decisions about their care and support and had the opportunity each week to take part in house meetings. People knew the provider and told us this person was nice and kind to them. One person said, "I like [provider's name] he's my friend." It was clear from our observations throughout the inspection that people living at the service were able to raise concerns with both the provider and nominated individual when they needed and had good relationships.
• Relatives had confidence in the service, felt comfortable raising concerns and were confident these would be acted on. One relative said, "[Person's name] is looked after very well." Another said, "When I have needed to raise concerns these were dealt with." However, relatives had not been made fully aware of the various changes in management.
• Staff told us regular staff meetings took place, staff felt listened to and appreciated by the provider, and

cared about the people living at the service.
• The provider had been working with representatives from the local authority safeguarding and quality team following concerns identified to make improvements needed.
• The service had developed working relationships with other health and social care professionals which meant advice and support could be accessed as required.
• Professionals we spoke with said communication with the service had been difficult at times but felt staff had made referrals appropriately/timely and followed advice they had been given.

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 manager had not notified the CQC of significant events in line with their legal responsibilities. Regulation 18 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the principles of the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way. Risks to people's health and safety had not been identified or mitigated. Medicines were not always stored securely. Regulation 12(1)(2)(a)(b)(c)(d)(g)(h)(i)

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 Systems and processes had not been established or operated effectively to investigate immediately upon becoming aware of any allegation or evidence of abuse. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service. The provider had failed to maintain accurate, complete and contemporaneous records for each person living in the home. Regulation 17 (1)(2)(a)(b)(d)(c)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider must ensure that recruitment procedures are established and operated effectively. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of qualified staff had been deployed to meet people's assessed needs safely. The provider had not ensured staff received the necessary skills required to carry out their duties.

Regulation 18 (1)(2)(a)

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 You failed to ensure that risks relating to infection control were being effectively managed and this placed service users and staff at an increased risk of harm. Regulation 12, section (1)(2)(a)(b)(h),

The enforcement action we took:

On the 23 November 2020, the Care Quality Commission served a warning notice under Section 29 of the Health and Social Care Act 2008 for failing to comply with Regulation 12, (1)(2)(a)(b)(h), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to become compliant with Regulation 12, section (1)(2)(a)(b)(h), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 30 November 2020.