Stoneyford Sc Ltd

Stoneyford Care Home

Inspection report

Stoneyford Road
Sutton-in-ashfield
NG17 2DR

Tel: 01623441329

Date of inspection visit:
28 November 2023
06 December 2023

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09 April 2024

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
Stoneyford Care Home is a residential care home providing accommodation and personal care to up to 58 people. The service provides support to adults, some of whom were living with dementia. At the time of our inspection there were 33 people living the service. The home had 2 floors and was divided into separate 3 sections. There was a communal garden to the rear of the home.

People's experience of using this service and what we found
People and staff at the home raised concerns about the care and support they were receiving. People told us they did not feel safe at the home as their care was not delivered safely, timely or in line with their wishes.

People described excessive wait times in response to call bells and a lack of support with personal care such as showering and toileting.

There was a shortage of trained staff which had impacted on the care they were able to offer people. Staff stated they had raised this repeatedly with the registered manager, but no action had been taken.

Care plans were not person centred and did not reflect people's needs. Risk assessments had failed to fully identify or mitigate risk. This meant that staff did not have the required information to support people in a safe manner nor in line with their wishes. Where risks had been identified, such as pressure care, there was no evidence to show people received support in line with the recommendations which meant that people were at increased risk of ongoing harm.

The home had recently undergone some renovations and people and staff were positive about these changes. However, the cleanliness of the home did not meet standards to control and prevent the spread of infections. Domestic staff were employed but they were often asked to support in other areas of the home due to staffing issues.

People and relatives told us they had raised incidents and complaints with the registered manager and the provider, but limited action had been taken and their concerns had not been fully addressed or formally responded to.

Staff told us there was a blame culture within the home which had hindered their ability to raise concerns. Staff described incidents of being 'shouted at' and 'talked down to' by the provider. Relatives and a professional working with the service supported these comments.

People were not supported to have maximum choice and control of their lives. While staff were knowledgeable about people's needs they were not able support them in the least restrictive way possible and in their best interests as the systems and care plans in the service did not support this practice.
Staff we spoke with told us the home had changed since the new provider had taken over and this had

adversely impacted the care people received. Relatives supported this and commented that communication and updates were lacking and there was a visible absence of management within the home.

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 the service under the previous provider was good, published on 26 September 2020.

Why we inspected

The inspection was prompted in part due to concerns received about staffing and person centred care planning and delivery. A decision was made for us to inspect and examine those risks.

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

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Enforcement

We have identified breaches in relation to, staffing, safeguarding people from avoidable harm, safe care and treatment, personalised care, consent to care, complaint handling and governance at this inspection.

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

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

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**

Stoneyford 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 Health and Social Care Act 2008.

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 was carried out by 2 inspectors, a specialist advisor who was a registered nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Stoneyford Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Stoneyford Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection, there was a registered manager in post. However, this person had tendered their resignation, and a new manager was being inducted to the service.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 28 November 2023 and ended on 6 December 2023. We visited the service on 28 November 2023 and again on the 5 December following receipt of further concerns.

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 and the local integrated care board. We contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people living at the home and 9 relatives about their experiences of the care provided. We reviewed in part, 8 people's care records and multiple medicine records.

We spoke with 18 members of staff including care staff, senior care staff, domestics, maintenance person, activity co-ordinator, administrator, manager, director, and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with two visiting external health professionals who visited the service to gather feedback on the care provided.

Following our visit we continued to seek further information related to people's care records, policies and procedures, staff training, quality monitoring and auditing processes as part of the inspection.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
● Staffing and recruitment was not undertaken safely. People, relatives and staff told us there were not enough staff to meet people's needs and this impacted on the care people received.
● People and relatives told us they experienced call bell wait times in excess of 60 minutes and were not assured that staff would attend to them if them used the call bell in an emergency. One person living at the home said, "There are certain times of the day when there is no point in pressing your buzzer as staff won't come, they are just too busy. It's not their fault, there simply isn't enough of them."
● Records indicated that where people required repositioning to prevent pressure damage these turns had not been completed. Staff told us there were not always the staff available to meet this meet within the timeframes. This placed people at risk of harm from not receiving care appropriately and timely.
● On the day of inspection, staffing levels did not meet the provider's dependency tool for required staffing amounts. We informed the provider who acted immediately, however staff confirmed this was a regular occurrence and the provider had not acted previously when they had reported their concerns.
● One staff member said, "I do worry about residents not getting the care they deserve due to staff shortages." Another staff member said, "There are so many times there are only 3 staff instead of 5, we can't possibly meet everyone needs, we have told them [management] but nothing happens."
● Recruitment systems were not robust and did not ensure people were safe. For example, new staff and agency staff had not received an induction and did not have all appropriate checks in place prior to supporting people independently. This meant people were at risk of receiving their care from unsuitable staff.
● Another staff member said, "I haven't had a competency check since I started, I think im doing things right. There is no communication or feedback, the seniors are fantastic but there is only 1 per shift and when they're doing medicines there is no one to help you, it's very stressful."

The provider failed to ensure there was adequate safely recruited and inducted staff members. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Following our inspection the provider told us they had upgraded their call bell systems and had made improvements to the waiting times for people at the home. We will check this on our next inspection.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management
● People were not protected from the risk of avoidable harm or abuse. Staff had received training in safeguarding and there was a policy in place however, staff told us they did not have time to spend with people to listen to their concerns and identify possible issues.

● People and relatives told us they had raised safeguarding concerns with the registered manager and provider and received no response. One relative said, "I have repeatedly raised concerns my [relative] does not get their full care, the staff try but it falls on deaf ears with management."
● Not all care plans contained appropriate risk assessments in line with people's health conditions. For example, staff told us people required support with use of a slide sheet. Slide sheets are used to support people to move and reposition. Care plans did not reflect this need and on inspection the provider was unable to evidence the home had any available to meet people's needs.
● Where risk assessments were completed, these were not always accurate and did not reflect people's current needs. For example, staff told us, a person required 2 staff members to support them with mobility aids. Their risk assessment showed no mobility aids were required and 1 staff member was needed to support. This placed people at ongoing risk of harm.

Using medicines safely
● Relatives told us they had concerns that there loved ones were not receiving their medicines on time. People we spoke with stated the time of their medicines varied and there was no consistency.
● One relative told us their loved one required medicine upon waking. "I have visited at 11am and [name] has not had that medicine yet." A person living at the home said they been offered 'as needed' pain relief twice in a short space of time by different staff members. The provider acknowledged this could have happened at busy times if staff had completed Medicine administration record (MAR) charts retrospectively.
● We reviewed multiple people's MAR charts which showed people received their medicine, but times were not specified clearly. This meant people were at risk of receiving their medicine at inappropriate times.
● Medicines were not always managed safely. On inspection we found medicines down the side of a chair within the communal lounge. This meant people were at risk of harm from not receiving their medicines or people having access to medicines not prescribed for them.
● Concerns were also raised that topical medicines such as creams were not always administered as prescribed. We reviewed the topical MAR charts. Staff used both electronic and paper charts to record the application of these medicines. There were significant gaps in the paper records that did not match the electronic records so we could not be assured people had received their medicine as prescribed.
● Medicine trolleys were not always secured as per guidelines when not in use. We alerted the provider to these concerns, and they took immediate steps to rectify the issues.

Preventing and controlling infection
● The service did not follow or meet national guidance in relation to infection prevention and control (IPC) which placed people at risk of infection.
● Equipment, furniture and aids were found to be dirty. For example, we found significant food debris in chairs in the communal lounge and shower chairs which had not been maintained and were stained with faeces.
● Staff wore PPE correctly. However, relatives told us that this was not normal practice. One person living at the home said, "Some staff wear it, but most don't they are always too busy."
● Staff told us they were unable to maintain the hygiene levels within the home due to staffing levels and domestic staff being allocated to other areas of the home. The nominated individual confirmed this had happened when care staff were absent at short notice.
● Staff had received infection prevention and control training. However, there was no evidence their competency was assessed. Audits had failed to identify the issues we found on inspection.

The provider failed to ensure risks were identified and mitigated, medicines were managed and administered safely and that correct procedures to prevent and control the risk of infection were implemented and followed. This was a breach of regulation 12 of The Health and Social Care Act 2008

(Regulated Activities) Regulation 2014.

We raised this with the provider who have told us they will be making improvements the auditing of IPC at the home. We will check these at our next inspection

● Where people required 'as needed' medicines there where clear and robust protocols in place for staff to follow.

Visiting in care homes

● People were able to welcome visitors to the home without restriction.

Learning lessons when things go wrong

● Lesson were not always learned when things went wrong. Staff told us they were discouraged from raising concerns as there was a blame culture.

● Where staff had raised concerns, they told us no action had been taken and their concerns had not been acted upon or investigated. For example, multiple staff members told us they had raised concerns about IPC and medicines being overstocked but the issues remained on this inspection.

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

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider did not always ensure that people's consent to care and treatment was sought. Management did not consistently audit or check consent activity.
● Where people required support with best interest decisions, these were completed by staff and did not show any professional or family / advocate involvement. This meant people were at risk of receiving care and treatment against their wishes.
● A relative told us, "I have repeatedly asked to be included in these types of decisions but I'm still waiting. I feel I have to be here more and more to ensure [name] gets the care they need."

The provider failed to ensure people's consent to care and treatment was received effectively. This was a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Where people required legal authorisation for restrictions, DoLS applications had been made to ensure these restrictions were lawful.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always supported to access other services in a timely manner.
● One person living at the home said, "I reported to staff on 3 separate occasions I wasn't feeling well, and I

ended up calling 111 myself." Another said, "The home doesn't seem keen on phoning for doctors, and they seem to action things very slowly."
● Where people had been referred to other professionals, their recommendations were not always recorded, and people relied on staff's knowledge of the care advice. This meant people were at risk from not receiving their care or receiving inappropriate care.

The provider failed to ensure people's needs were assessed, staff were not always suitable trained to be able to support people appropriately and access to other services and professional was not always acted upon in a timely manner. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● People's needs were not always comprehensively assessed, and we were not assured that people were receiving care in line with current standards.
● One person required support with catheter care. This had not been assessed and there was no guidance to support staff in delivering this care. Staff told us they sought support directly from district nurses to meet people's needs with catheter care. This meant people were at risk of not receiving their care or receiving it inappropriately if a district nurse could not be contacted in a timely manner.
● People and relatives were not involved in the assessment of their needs and were unsure if their care plans reflected their personal choices. Relatives told us their request to be included, and requests for copies of assessments had not been acted upon.

Staff support: induction, training, skills and experience
● People were not always supported by staff who were suitably trained or experienced.
● On the second day of inspection there were 4 members of staff working independently with people. They had not received an induction or completed mandatory training such as manual handling and health and safety.
● We spoke with staff members who confirmed they had not been introduced to people or provided with their care plan prior to supporting them with their care. This meant people were at risk of harm from receiving their care inappropriately or not in line with their wishes.

Supporting people to eat and drink enough to maintain a balanced diet
● People's hydration and nutrition were not sufficiently monitored to manage their needs or requirements.
● One person's care plan showed, without support, they would not remember to eat or drink. Records showed days where only one meal was recorded as being offered. This meant the person was at risk of not receiving a balanced diet.
● Where people required charts to record their fluid intake these were not completed. This meant people were at risk of harm from not receiving their required daily fluids to support their conditions.
● We spoke with staff and management about the concerns, and they were not able to confirm whether people were offered fluids consistently. The provider took immediate action to ensure this was offered and recorded.

Adapting service, design, decoration to meet people's needs
● People were involved in decisions about the premises and environment and the home had recently undergone refurbishment in communal areas.
● People were able to choose the decoration within their own bedrooms and were supported by staff. People told us they felt at home.
● At the time of inspection there was no dementia friendly signage in the home, However the provider was in

the process of replacing this following the renovation.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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
- People were not always supported with kindness and dignity in a timely manner. Staff told us their workload meant they were more task focused and had little time to support people's wellbeing.
- One staff member said, "I used to get time to sit with people, socialise and get to know them, I can't do that anymore and it breaks my heart."
- People and relatives praised the staff for their kindness but told us there was not enough staff to ensure they received the care they needed. One person told us, "Recently the staff ratios have deteriorated. The staff are good, but they are struggling because of workload pressures, they have no option to rush in and rush out again when you call them."

Respecting and promoting people's privacy, dignity and independence
- People privacy, dignity and independence was not always respected or promoted.
- Multiple people living at the home gave examples of their dignity and independence not being promoted and we observed staff entering people's rooms without knocking or seeking permission.
- One person told us there call bell had been left out of their reach on several occasions and they had had to phone a relative to ask for assistance as they could not alert staff.

Supporting people to express their views and be involved in making decisions about their care
- People were not supported to express their views and were not always involved in making decisions about their care.
- People told us they did not have access to their care plans and were not involved in reviews about their care. One person said, "My care plan was done with me when I moved in, but it hasn't been mentioned since."
- The care plans reviewed on inspection showed staff were completing reviews and updates, however they did not show people's involvement and they did not seek their feedback.

The provider failed to ensure people received person centred care that reflected their needs and had been devised and updated with their input. This was a breach of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
● Complaints were not dealt with in an open and transparent or responsive way. Relatives told us the provider was defensive when complaints were raised at meetings. A professional working with the service who attended a meeting supported this.
● One relative said, "I have raised complaints, and nothing happens, there is no response. At the meeting recently the [provider] blamed staff outright for the issues we raised, this was in front of staff and residents, it was awful."
● One person told us, "I raised a complaint with the registered manager and was told it was with HR, I have never heard anything back."
● The provider had a complaints policy; however complaints were not logged consistently and there was no evidence to show any learning had been applied to prevent incidents or address concerns.

The provider failed to ensure complaint were investigated and responded to. This was a breach of regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 and relatives told us they were not involved in developing and reviewing their care regularly. Individuals needs and wishes were not fully reflected with care plan.
● One person said, "I haven't got peace of mind with this service at the moment" and another said, "I wasn't included in the care plan so I don't know if it reflect [name's] needs but it doesn't matter what the care plan says if the staff don't have time to follow it."
● New staff and agency staff did not always have access to people care plans to ensure personalised care could be delivered.
● People living at the home told us there were large periods of time they were in the lounge without support from staff or activities to engage in. One person said, "When we are in the lounge, we can get very frustrated and agitated because staff can't hear us. There's never a staff member watching the lounge'.
● There was an activities co-ordinator employed, however care plans did not reflect how people wished to spend their time and did not document when activities had been offered or participated in.
● People were not always supported to participate in activities that were important to them. One person told us they would like to spend time outside in the garden and another said they would like to go into the community. We spoke with management about these requests, and they were not aware of people's wishes.

End of life care and support

● At the time of our inspection no one was in receipt of end of life care.
● Advance decision planning in anticipation of end of life or emergency care was not effective. The provider had failed to identify issues with the Summary Plan for Emergency Care and Treatment (ReSPECT) forms people had in place. ReSPECT forms contain a summary of personalised recommendations for a person's clinical care in an emergency. Many of the forms lacked person centred information and did not contain the required mental capacity assessments.
● Staff were not knowledgeable about where to locate these forms. Hard copies of forms were at times locked in an office that staff did not have access to.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The provider had not complied with Accessible Information Standard and people's communication needs had not always been assessed or fully documented within their care plans. The manager acknowledged this and advised a full review was planned.
● We spoke with the manager and staff about how they ensured information was accessible for all people using the service. They told us, about different communication styles in place to support people. For example, they had information in large print, or in easy read l format available if required.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Managerial oversight of care plans was inconsistent, and where had been reviews completed this had failed to identify inconsistencies we found on inspection. For example, people's manual handling needs were not documented correctly. One person required support with a hoist by 2 members of staff. Their care plan stated they were independent.
- Where people's needs and choices had been assessed, staff did not always have access to this information. For example, the provider confirmed that during a recent emergency, staff did not have access to people's records as they had been locked in an office overnight.
- Staff told us they did not receive supervision and team meetings did not take place consistently. One staff member said, "We have occasional staff meetings, but we don't seem to be listened to."
- The lack of activities and meaningful engagement with people meant people spent large periods of time isolated with little activity or socialisation, this did not promote a positive or person-centred culture.
- As evidenced throughout this report, people were not included in their care planning or delivery and staff feedback was not sought. This meant people's dignity and independence was not promoted and people did not receive person centred care in line with their wishes.

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

- People told us the service was not well led. Relatives and staff told us there was a culture of blame with the home. Staff stated the provider was 'defensive' if they raised concerns and they were often spoken down to.
- There was no clear oversight of staffing levels and staff's daily responsibilities. One staff member said, "We are left to fend for ourselves. Management often don't answer the phone if we call them for support."
- People did not know who the manager or providers were. One person said, "I don't know the managers and wouldn't know them if they came in my room." A relative told us, "When the owners do come into the home, they never speak to you."
- The provider had cleaning schedules and audits in place, however these were not effective and had not found the issues identified on inspection. The provider acknowledged the shortfall as domestic staff were often required to support in other areas of the home.
- The manager and provider acknowledged audits and daily checks, such as the managers walkaround and

flash meetings with staff, which are an opportunity to identify issues and gain staff feedback, were not documented or acted upon. This meant concerns around staffing, infection control, safe care and treatment, complaints and personalised care planning were not identified or addressed.

Continuous learning and improving care; Working in partnership with others
● There was no evidence of learning or reflective practice at the home to promote improvement.
● Audits were not completely consistently or comprehensively which meant repeated opportunities to identify issues and make improvement had been missed.
● During the inspection we saw meetings being held with other professionals such as district nurses and social workers to discuss people's care, however people and their relatives were not present at these meetings.

The provider failed to ensure the quality, safety and leadership of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On receiving our feedback during the inspection, the provider took steps to immediately address some of the concerns raised. The provider agreed to increase staffing levels to ensure peoples safety whilst improvements were made.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received person centred care that reflected their needs and had been devised and updated with their input.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's consent to care and treatment was obtained. Where best interest decision had been made these did not include the appropriate professionals or family and advocates.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure complaints were investigated and responded to. There was no evidence of the provider applying learning to the service to prevent reoccurrence of incidents or concerns

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the quality, safety and leadership of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensured there was enough trained and experience staff to support people in line with their needs

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 ensure people were protected from the risk of avoidable harm and abuse as staff were not recruited or inducted safely into the service. Issues with infection prevention control had not been identified or addressed and medicines were not managed or administered safely.

The enforcement action we took:

We issued the provider with an urgent notice of decision to impose condition on their registration.