Haresbrook Park Limited

Haresbrook Park Care Home

Inspection report

Haresbrook Lane
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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Haresbrook Park Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service provides accommodation and personal care for up to 57 people. There were 54 people living at the home all of whom received residential care.

People's experience of using this service:

The service was not safe. People continued to be at risk of harm through the lack of competent staff. We saw staff put people at risk through their poor practice. The provider failed to meet regulations to ensure people were safe and had their needs met. Systems to ensure people were safeguarded from abuse were not always effective. Accidents and incidents were not always reviewed to ensure lessons were learnt. People were at risk of harm, systems to protect people were not always completed and were ineffective at identifying and managing these risks. People did not always have their prescribed creams when they should do, they were at risk of sore skin.

People did not always have their needs met because of the lack of competent, knowledgeable staff who knew them. Staff continued to support people despite concerns about their practice identified by the management team.
The service was not always effective. Care was delivered by staff who were not always trained, skilled and knowledgeable about people's care and support needs. People's needs were assessed however people's needs were not consistently met. People had a nutritious diet, and they enjoyed the food offered. The management overview needed to be improved to ensure the principles of Mental Capacity Act (2005) were complied with, and staff knowledge and understanding improved. People were supported to access the health care they needed.

People and their relatives had some positive comments about the care provided. However, some relatives were concerned about staffing levels, and we found people were cared for by staff who were sometimes task focussed because they were rushed or lacked the competency to support people. Staff were kind to people, however sometimes they were not available to meet people's needs when they were upset. People's privacy was not always upheld because people wandered in and out of other people's rooms.

People did not always have access to interesting things to do. The management team were recruiting for extra staff to improve people's well-being. Relatives did not always feel their complaints had been actioned.

The service was not well led. The provider continued to not have effective governance systems in place to identify shortfalls in the quality and safety of the service for the third inspection in three years. The providers governance systems had failed to ensure people were protected from the risk of harm, and that there were

sufficient suitably skilled staff to meet people's needs. Systems to provide an overview of accidents, incidents and safe guarding's were ineffective therefore there was a lack of continuous learning and improving people's safety and outcomes.

Rating at last inspection: Comprehensive inspection completed June 2018. The overall rating was requires improvement. There were breaches in regulation that continue not to be met and sufficient progress to improve people's care had not been made.

Why we inspected: This was a responsive inspection bought forward because of concerns raised by other Authorities and whistle blowers about people's safety.

Enforcement: We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulation 12 safe care and treatment, regulation 18 insufficient competent staff to meet people's needs and regulation 17 there was continuous systemic failure in the effectiveness of governance systems. This was the third inspection in three years where there was a continuous breach in this regulation.

Please see the end of the full report for what action we took.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Please see our detailed findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Please see our findings below.

Is the service caring?

Requires Improvement

The service is not always caring.

Please see our findings below.

Is the service responsive?

Requires Improvement

The service is always responsive

Please see our findings below.

Is the service well-led?

Inadequate

The service was not well-led

Details are in our findings below.

Haresbrook Park 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors 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.' Their area of expertise was dementia care.

Service and service type:
Haresbrook Park Care Home is a care home without nursing care for older people and people living with dementia. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (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. The provider was in the process of recruiting to the managers post. The registered manager with the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This was an unannounced inspection that took place on the 23 and 24 May 2019.

What we did:
We reviewed information we had received about the service since the last inspection. This included details

about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority and we assessed the information in the provider information return. This is key information providers are required to send us about their service, what they do well, and improvements they plan to make. This information helps inform our inspections.

During the inspection, we spoke with seven people who used the service, to ask about their experience of the care provided and five visiting family members. 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 spoke with 12 members of staff including care staff, the cook, the administrator and maintenance person. We also spoke with the regional manager, quality assurance manager and the nominated individual. We spoke with three visiting professionals a community nurse team leader, an Advance Nurse Practitioner and a community foot specialist.

We reviewed a range of records about people's care and how the service was managed. This included looking at five people's care records and a sample of people's medicines administration records. We reviewed records of meetings, staff rotas and staff training records and four staff files. We also reviewed the records of accidents, incidents, complaints and quality assurance audits the management team had completed.

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 on 5 June 2018 this key question was rated as Requires Improvement. At this inspection the rating had deteriorated to Inadequate.

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; Preventing and controlling infection; Assessing risk, safety monitoring and management; Learning lessons when things go wrong;

●At our last inspection we found people were at risk of harm. We found at this inspection that the provider had taken inadequate steps to reduce the risks for people living at the home. People continued to be exposed to the risk of harm.

● At our last inspection we saw people were walking in and out of other people's bedrooms placing them at risk of harm through unobserved falls and safe guarding incidents as some people were assessed as high risk of falls and at risk of harming others. At this inspection we found this continued to constantly happen. A number of people living at the home had been assessed as at severe risk of harming others. For example, one person's risk assessment showed that staff were to monitor interactions with other people, however we saw people were walking in and out of people's bedrooms, throughout the day when staff were not in the area. There had been no action taken to manage the risk of injury and to mitigate the potential avoidable harm.

●At our last inspection we found the provider had not always reviewed and actioned accidents and incidents to ensure there was an over view to identify trends and learn from incidents to prevent a reoccurrence. At this inspection we continued to find examples of incidents not reported to the management team. For example. we found two people had accidents on the same day and this information had not been shared with the management team for their investigation and review. The provider failed to ensure accidents and incidents were consistently reviewed, actioned and lessons learnt to improve people's safety.

●Staff understood their responsibility to report safe guarding incidents, however the provider had failed to ensure incidents were recorded and reviewed and consistently reported to meet their legal responsibility. We found some safe guarding incidents had been actioned by team leaders but not consistently reported to the management team for their overview and to report to the Care Quality Commission.

●People were at risk of injury because of poor practice from care staff. Staff did not always support people in a safe way. We saw a member of staff put a person at risk of a potential fall because they had not communicated with the person or followed safe practice when supporting them with their care. We saw other members of staff use poor techniques when supporting a person to mobilise despite the staff

members attending training.

●People were put at risk of infection because the provider had not ensured staff followed safe practice. Staff failed to consistently follow infection control procedures and put service users at risk of infection. We saw a member of staff put people at risk through their poor practice when cleaning up a spill of bodily fluids. There was a lack of equipment such as slings to support people to mobilise which increased the risk of infection as people were sharing this equipment. There was only one electric razor and a lack of nail clippers which meant staff told us they were using the same pair for many different people, increasing the risk of infection.

●The provider failed to assess and mitigate environmental risk. Seven first floor windows did not have restrictors on the top part of the window which was deep enough to climb out of. These were situated in two communal rooms where there were chairs that people could have climbed on. The regional manager and quality assurance manager agreed there was a high potential of risk and took immediate steps to address and mitigate the risk.

●People were at risk of sore skin through poor management of people's topical medication. People did not always have their topical creams as prescribed. We reviewed the topical cream medication records and found three examples where people had not had their creams as prescribed. There was a lack of guidance for staff and oversight from senior staff to ensure records were accurate and completed so that gaps in recordings could be investigated and actioned.

●Staff were not always up to date with policies in the home to keep people safe. A person arrived from hospital in the evening with a change in medication which needed community nurse input. The team leader explained that it was not the policy of the home to admit people after four pm as they would not have time to resolve any medicine discrepancies. While this was resolved the next morning, the person was put at potential risk of harm through delay in receiving the right medicine as the procedures had not been followed.

This was a breach in Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12: Safe care and treatment. The provider failed to ensure people were supported by staff that were competent and skilled. This put service users at risk of poor and unsafe care

Staffing and recruitment;

●There were insufficient competent staff to meet people's needs. There was a reliance on agency staff to fill the gaps in the rota. Some agency staff did not always have the experience and competency to meet people's needs. For example, two staff were not clear on their roles and understanding when supporting people. We saw more experienced staff continually have to support less skilled staff with basic tasks which impacted on their workload. Therefore, despite there being the correct assessed number of staff on duty, because of the lack of competent skilled staff, this reduced the level of support available to meet people's needs.

●A visiting professional told us there was a high turnover of staff and that many of the agency staff had little understanding of the English language which impacted on people's support and other staff told us they had to pick up the extra work load.

●People living on unit Glen View could not access communal areas of their home because of lack of staff to maintain their safety. Staff we spoke with said this was because they were unable to monitor people in that

area and there was a history of people falling in this area. The main access to the garden for people on Glen View was through the dining room. The provider confirmed that there were insufficient staff on Glen View to ensure people were safe when accessing the dining room between meals therefore they had locked the doors of the dining room preventing access.

●Staffing levels on Glen View were insufficient to meet people's needs. The quality assurance manager had assessed each service user's dependency level and this was staffing level was in place at the time of the inspection. However, the team leader for Glen View and the quality assurance manager agreed that staffing levels needed to be increased on Glen View during the day, this was not in place during the inspection.

●People living with dementia did not have support from a consistent and stable staff team who had the skills and knowledge to support people who lived with dementia. We saw there was a regular use of agency where there were new staff regularly supporting people with complex needs.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18: Sufficient suitable qualified staff. The provider failed to ensure there were sufficient competent staff on duty to meet people's needs.

Recruitment;
●Staff told us they had provided references and there were checks in place to ensure they were suitable to be employed at the service. We found that the provider used safe practices when recruiting staff to ensure people were protected from unsuitable staff.

Using medicines safely;
● For medicines other than topical creams we saw staff administered medicines in a safe way, following guidance, and using an effective system to ensure people had their medicines as prescribed. Staff administering medicines were trained and had competency checks to ensure they followed safe practice. Medicines were stored and monitored safely.

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 on 5 June 2018 this key question was rated as Requires Improvement. At this inspection we found this key question remained the same Require Improvement.

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

Staff support: induction, training, skills and experience;

● People did not receive support from staff that were competent and skilled. Not all staff were up to date with their training. Staff told us they had completed training when they first started the role. We saw examples of poor practice carried out by some staff. For example, we saw two staff use poor moving and handling techniques which put people at risk of harm and one staff member was not effective at managing infection control. These staff had received training but had not applied their learning and their competency had not been checked. The management team were aware that some of their staff were out of date with their training and had identified some staff lacked the skills and experience to support people. While the provider informed us, those staff would be leaving the service, at the time of the inspection they continued to provide ineffective care and support for people.
● The provider had failed to ensure staff had the skills to meet people's needs. Most of the people living at the home lived with a dementia, however we saw from the provider records that only 52% of staff in March had completed dementia awareness training. We saw staff not explaining what they were doing when supporting people which increased people's confusion.
● The provider did not use the care certificate to establish a nationally agreed knowledge base for staff working at the home. The provider did provide training for staff they had not undertaken competency or spot checks to ensure staff had learnt and understood what they had been taught.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18: Sufficient suitable qualified staff. The provider failed to ensure there were sufficient competent staff on duty to meet people's needs.

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 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 service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•Relatives told us staff usually checked people consented to their care. However, we saw that some staff did not always check and explain to the person before they began supporting them. For example, we saw one staff member consistently did not explain to people who lived with dementia but went straight into the task of supporting people. We saw people were upset and confused when this happened.
• Some staff did not have a good understanding of the principles of the MCA to understand how this may affect the way the person is supported.
• The provider could not be assured those people who were being deprived of their liberty had the authorisation in place for them to legally do so. Where some people had a DoLS in place, there were conditions set out by the authorising authority, we found that one person had not had their condition met from November 2018.
● The management team had identified some staff lacked in knowledge around MCA and had plans in place to address this. The management team acknowledged they needed to review all people's care files to check the MCA was complied with.
•When people could not make a decision about aspects of their care, we saw examples where the team leaders had completed a decision specific mental capacity assessment and best interest's decision involved the person's family and healthcare professionals.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
●People's health and social care needs were assessed and documented with their preferences in relation to their care.
● Relatives told us although they had concerns about some staff others worked hard to meet their family member's needs. For example, a relative explained how their family member had settled well at the home and the person's well-being had improved.
● We saw assessment tools and information on best practice guidance was available for staff.

Supporting people to eat and drink enough to maintain a balanced diet;
● People and relatives said the food had improved and they were happy with the menu available. People had choices in the meals they were offered, with alternatives being given if people did not want what was on the menu that day.
●We saw people were offered drinks and snacks through the day and enjoyed their meal time experience.
●People were supported to eat when they needed extra help, staff supported them at people's own pace.
●Where people needed specialised diets, the chef was aware and provided food to meet those needs.

Adapting service, design, decoration to meet people's needs;
● The environment was not adapted to people's needs as their needs and associated risks had not always been considered. For example, window restrictors were not in place in communal rooms on the first floor. Corridors were wide enough for easy wheelchair access. There was clear signage for people, with some focus on design to support people living with dementia. People's bedrooms were kept clear of personal items. One relative said this was because of the constant number of other people wandering into rooms.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care;.
●We received positive feedback from the community nurse team leader, a foot specialist and an advance

nurse practitioner who regularly visited the home. They told us they had a good relationship with the team leaders and staff followed professional's advice.

- Relatives explained their family member could access healthcare services when they needed.

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 two inspections we rated this key question as Requires Improvement. At this inspection we found the key question remained the same Requires Improvement.

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;
● The provider had not ensured people were supported by knowledgeable staff who had a clear understanding of people's needs when living with advanced dementia. The provider had inexperienced staff working at the home which meant those staff with the skills to support people with dementia lacked the time to do this consistently. We saw some staff were task focussed and lacked the understanding of the English language to communicate with people living at the home. We saw examples where staff didn't communicate with people before they supported them, these people became upset because they did not understand what the member of staff was doing. We saw other staff had the skills and understanding to support people however they lacked the time to consistently apply these skills when people needed the support.
●At our last inspection the provider assured us that there would be additional training for staff to improve their understanding of dementia. We found this had not consistently improved staff understanding, and some staff continued to be task focussed.
●Relatives told us staff tried really hard and were very kind to their family member. However, most relatives agreed there could be improvement in the workload for staff to give them more time with their family members.
●We saw examples where people were not supported when they were upset or confused. We saw this was because staff were busy elsewhere and therefore people's well-being was not improved.

Respecting and promoting people's privacy, dignity and independence;
● People did not always have their privacy and dignity maintained. We saw people walking in and out of other people's rooms while people were sometimes in bed or in their room with the door shut, this culture was accepted by staff. We spoke with one member of staff and they did not see this as an issue for people's privacy. We had raised this concern at our last inspection and saw no evidence of improvement in promoting people's privacy at this inspection.
●Staff did not consistently maintain people's dignity and independence. We saw some staff were good in promoting people's independence and dignity whilst others did to people instead of working with them. For example, we saw a member of staff just start supporting a person to eat, without involving the person or conversation with the person. We also saw staff keep leaving people whilst they were supporting them to eat to complete other tasks.
● The provider had not ensured people were treated with dignity. Personal toiletries such as electric razors and nail clippers were shared across the home rather than personal for individuals to have access to.

Supporting people to express their views and be involved in making decisions about their care;

● People and their families said they were involved in making decisions about their care. We saw some staff constantly offered choice and encouraged people's involvement in decisions. For example, about what people wanted to eat or drink.

●However, we saw other examples where people were not consulted. For example, we heard in one area of the home a radio was constantly on playing very modern music. When asked people said they were not listening to it as they did not understand what it was.

●We saw there were meetings for people and their families to discuss their views and to look at any improvements to the home. One relative told us at the last meeting, approximately a month before our inspection, they had raised concerns about staffing levels and the lack of understanding of English with some staff and nothing had changed.

●Some people chose to get up later and staff provided breakfast when people wanted it, however people were not able to eat in the dining room because this was locked after the main meal times.

●Relatives we spoke with told us that they felt involved in the care of their family member and were kept updated by staff and the management team.

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 on 5 June 2018 this key question was rated as good. However, at this inspection we found that this key question has deteriorated to Requires Improvement.
Response: People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control;
●One person told us they had, "Not a lot to do really." They went on to say they had gone for a walk with a member of staff last week. We saw throughout the morning this person spent time sitting in the lounge and walking in corridors. People lacked interesting things to do with their day. There were two vacancies in the team of staff that provided activities for people to do, there was a lack of resources to meet people's needs. The management team had not increased staff to support this to ensure people had meaningful occupation to support their well-being. The management team were trying to recruit additional staff for these vacancies and acknowledged these posts were important for people's well-being
●People and their relatives shared important information with staff to help build a detailed picture about each person's care needs, preferences and history. Regular staff had the knowledge to provide personalised care however, because of the constantly changing staff, and agency staff this impacted on the care provided.
● Records contained detailed information for staff on how best to support people with personal care, eating and drinking, medicines and other day to day activities. Information also reflected their health needs.
●Regular staff knew how to communicate with people to understand their wishes and when people were less able to communicate verbally, we saw some staff observed people's facial expressions to gauge their preferences.
●The management team were aware of the accessible communication standards and we saw there was clear direction to staff about people's communication needs.
●People and their families told us support was adapted to meet people's needs.

Improving care quality in response to complaints or concerns;
●Relatives said they could complain if they needed to, one relative said they had complained about staffing but had not seen improvements made. We saw where complaints were made these were investigated and the complaints policy followed by management team. The provider had not always taken action in a timely way to make improvements.

End of life care and support;
● Some staff were knowledgeable about meeting people's needs at the end of their life. One member of staff told us there was good support from professionals when people needed the support. The management team told us they were reviewing the information recorded about how people wanted their support at that time.

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 in two inspections in July 2017 and June 2018 this key question was rated Requires Improvement. At this inspection this key question had deteriorated to Inadequate.

At this inspection we found the provider had continued to fail to meet Regulation 17 HSCA RA Regulations 2014 good governance.

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. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support with openness;

●There was no registered manager in post at the time of our inspection, the registered manager had left the service four weeks before the inspection. There was support from the regional manager and the quality assurance manager. There were multiple staff vacancies and a reliance of agency care staff at the time of the inspection. Staff, and relatives were not sure of what was happening at the service. Staff told us there had been a culture of the management team not engaging well with staff.

● The provider had failed to implement effective governance systems to monitor and improve the quality of care. This had resulted in people's experience of receiving care at times being poor and exposed people to the risk of harm. Services rated as requires improvement are expected to focus on improvements to achieve a rating of good. This service has been rated as requires improvement for the last three inspections and has been in breach of regulations since July 2017.

● There were continuing failing since our previous inspection. People continued to enter other people's bedrooms resulting in incidents and increased risk of harm. The provider had not considered effective strategies and had at times adopted restrictive practices.

●The providers systems failed to ensure people received quality care from staff that were suitably trained and competent who follow safe practice. We found there to be high usage of agency staff and no evidence that staff's competencies were checked and maintained. The staffing assessment tool had not taken into account the lack of skills for some staff and the other vacancies such as activity coordinator that impacted on people's health and well-being.

●At our last inspection the providers governance systems failed to identify shortfalls in managing safeguarding processes and managing DoLS . At this inspection there continued to be unidentified short

falls in these areas. We found there was a mismatch of information recorded on the system to ensure DoLS were appropriately updated, and conditions complied with. Also, the management team failed to ensure safe guarding concerns were investigated and reported to the Care Quality Commission as part of their legal obligation. We found examples where the team leaders had taken the initial action and reported to the Local Authority, however the management team had not ensured they had reviewed for lessons learnt, monitoring, analysing, and reported to CQC consistently when required.

●There was systemic failures to learn from accidents and incidents through the management team's oversight. For example, the management team were aware that not all accidents and incidents where managed effectively for continuous learning. We found examples in daily notes of falls, that had not been passed to the management team for review.

●People were at risk of not having the appropriate equipment to support them when needed. There was a lack of equipment available to support people to mobilise in the event of a fall. The Quality Assurance Manager told us there was a policy to use single use slings, however staff said these were not in place at the time of inspection, and on one unit, there were no small slings available despite there being service users identified that may need them.

●Systems to ensure that the environment met health and safety regulations were not effective. Seven windows in communal room in a first story building did not have restrictors and this had not been identified as a risk to people.

This was a breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17: Good governance. There was continuous systemic failure in the effectiveness of governance systems. This was the third inspection in three years where there was a continuous breach in this regulation.

How the provider understands and acts on their duty of candour responsibility:
●Services that provide health and social care to people are required to inform the care quality commission of safeguarding incidents to protect people using their services. We found two examples where the provider had failed to report safeguarding concerns to the CQC.
This was a breach in regulation 18, CQC (Registration) Regulations 2009 failure to notify.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
●Meetings for people using the service and for relatives were held however one relative had raised concerns and had not seen any improvements.
●Staff told us they had meetings with the provider and felt like they were now being listened to. There had been some improvements to the rota's they worked which had improved staff well-being and given some confidence that things would improve. However other staff said they had not seen minutes from recent staff meetings and were not sure what was happening at the service.
● The management team acknowledged they had a long way to go to make all the improvements they needed. They had started working on an action plan to improve staffing levels and competency and address other areas of shortfalls in the service.

Working in partnership with others.
● Health professionals spoke positively about team leaders and staff worked effectively with them to improve people's health and well-being.

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 supported by staff that were competent and skilled. This put service users at risk of poor and unsafe care

The enforcement action we took:

NOD to add a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was continuous systemic failure in the effectiveness of governance systems. This was the third inspection in three years where there was a continuous breach in this regulation.

The enforcement action we took:

NOD to impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient competent staff on duty to meet people's needs.

The enforcement action we took:

NOD to add a condition to registration