Rainbow Of Care Limited

Alvaston House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Alvaston House Care Home is a 17 bed residential home providing personal and nursing care to 11 people at the time of the inspection. The care home supports people in an adapted building.

The service rarely applied (didn't apply the full range of) the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; lack of choice and control and limited independence. People did not have choice in the food they ate or at what times meals were served. Menus were developed by staff with limited input from people who lived at the service.

The care service should be developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Health and safety checks were not regularly completed or evidenced to ensure risks to people's safety were minimised. We brought some health and safety issues to the attention of the acting manager on the first day of our inspection visit where we had immediate concerns to people's safety. Staff recruitment procedures were adequate which ensured people were cared for by staff who had been assessed as safe to work with them. People's health and welfare was placed at risk from an environment that was not risk assessed in line with people's life history and the risks associated with that. There were no adequate infection control checks in place which resulted in a heightened potential for cross infection and cross contamination of infection in the home. The environment was in need of cleaning and some areas disinfected, there were areas of malodour that required attention.

The provider did not have effective systems in place to assess the needs of people prior to entering the home. People were (not) supported to have maximum choice and control of their lives and staff (did not support) supported them in the least restrictive way possible; the policies and systems in the service (did not support) supported this practice. Staff did not understand the Mental Capacity Act 2005 (MCA). Staff confirmed they had not been trained to care for people with enduring mental health needs, and no training records existed to confirm what training staff had completed. There was no system in place that allowed the acting manager to consistently supervise the staff to ensure people were safe in the home. People could cater for themselves and others were provided with a varied menu which met people's cultural needs, but choice was limited.

Staff observed people's privacy and dignity, but did not recognise they were employed to respect people's

environment and not intrude on their personal space. Staffing levels were adequate to provide basic levels of care.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. Care plans provided limited information for staff that identified some people's support needs, however there was little information about people's associated risks. There was enough staff on duty to respond to people's health and care needs, however, social care and pastimes were not seen as a priority and people were not supported with these. There was no complaints process or records in place. Staff had not considered people's end of life choices or made reference to this in care plans.

There was no evidence that any quality monitoring had been undertaken. The audit systems had not been put in place by the registered manager to ensure people received a quality service. Incidents were recorded but information was not always sent to CQC. Improvements are required in assessing risk to people. There was no access to policies and procedures which would give staff the information to operate systems effectively and protect people in the home.

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

This service was registered with us on 25/05/2018 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about allegations of financial irregularities. A decision was made for us to inspect the home but not look at the allegations and incidents that were subject to a Local Authority investigation.

Enforcement
We have identified breaches in relation to the safety of people in the service, safety and monitoring of the environment they live in. There are further breaches around assessing people's needs and the composition of care plans and the risks associated with caring for people.

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

Special measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. We have assessed the inspection outcome is so serious that people are placed at risk. We propose to cancel the provider's registration, and are in contact with the local authority to identify alternative accommodation.

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 effective. Details are in our Effective findings below.	**Inadequate**
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 responsive. Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Alvaston House 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.

The inspection was prompted in part by the information shared with CQC about the incident indicated potential concerns about the management of risk of by the provider, who was unable to access the home. The management of the home had been taken over by the building landlord who leased the building to the provider. We had concerns over people's safety.

Inspection team
On the first day of the inspection the team consisted of two inspectors. On the second day the team consisted of one inspector 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. The expert's area of experience was using mental health services.

Service and service type
Alvaston House 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not at the home at the time of our inspection and we were provided with limited information by the acting manager.

Notice of inspection
The inspection was unannounced. Inspection site visit activity started on 4 June 2019 and ended on 5 June 2019. We visited the service on 4 and 5 June 2019 to see the people living there, the acting manager and

office staff; and to review care records and policies and procedures.

What we did before the inspection
Before the inspection we spoke with local authority safeguarding, contracts and commissioning teams. We reviewed notifications of incidents received since the provider was registered in May 2018. We used all of this information to plan our inspection.

Due to technical problems, the provider was not able to complete a Provider Information Return. 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 spent time observing the care and support being provided throughout the home. 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 six people who lived in the home. This home is owned by a limited company, the nominated individual is appointed by the directors of the company to act on their behalf. We also spoke with the acting manager, the senior carer and two support staff.
We looked at the care records for three of the people who lived in the service. We also looked at records that related to how the service was managed including staffing rotas, recruitment, training and quality assurance.

After the inspection
We asked the acting manager to send us further documentation following the inspection which included copies of the training records, the staff rota and minutes of meetings for the people who used the home and staff meetings. These were not supplied following 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

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

Systems and processes to safeguard people from the risk of abuse

- Some people told us they felt safe in the home. One person said, "I feel safe here because of the staff and the cameras." Another person said, "I do not feel safe here, I had a meeting with my social worker and they are looking for another home for me to live at." Another person said, "Some residents make me feel unsafe, some pressurise me into giving them money." We followed these comments up and made a safeguarding referral to the local authority.
- Staff we spoke with were unsure of how they should protect people in the home. Staff told us they had not been trained in safeguarding and could not tell us what they should observe for, in case people were being abused.

Assessing risk, safety monitoring and management

- Risks to people posed by the environment had not been assessed. The home supported people, some of whom have previously attempted to take their own life. The environment of the home had not been risk assessed and was not ligature free. Staff were informed about the need to ensure people's safety, safety around the environment and their personal safety. However, there was no information in care plan documents of the people's previous attempts to take their own lives. The staff we spoke with were unaware of this danger.
- Risks around hot water were not assessed to ensure people were safe. Hot water was circulated around the home at or around 43C. This was to ensure that people could not be scalded by the hot water temperature. However, this allowed a potential for the hot water system to be infected with Legionella. The correct temperature for hot water circulation is above 68C and then the temperature to be reduced at the outlet.
- Due to the reduced temperature of hot water circulation a number of electric panel radiators had been fitted in bedrooms and corridors to provide additional heating in the colder weather. These were not guarded properly and allowed a potential burns risk if a person leant against them.
- We found that windows in the home had a device to regulate the opening distance. We found some had been removed and all the others could be removed by using a screwdriver. This could allow people in the home to fall through the window and potentially injure themselves.
- Staff had commenced recording fridge and freezer temperatures. However, when we looked at two freezers neither were cold enough to ensure food remained frozen and fit for consumption. Staff had recorded that the temperatures were minus 12centigrade, (freezer temperatures should be below minus 18 centigrade) but not reported this onto the acting manager.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection:

● People were not protected by the control of infection. People were not protected from the risk of infection because systems and processes did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. Some areas of the premises and some equipment was not clean and staff did not have the equipment they required for effective hand washing and hand hygiene. There was no soap or handtowels in the toilets, and there were no pedal operated bins to ensure infection controls were upheld. Where bins were in place, no liners were placed in the bin to cut down the potential for cross contamination of the equipment.

● On day one of the inspection the mops and buckets used to clean and disinfect the floors in toilets and public areas were stored outside a fire door, uncovered and open to the elements. These posed a clear cross infection and cross contamination issue. The colour coded mops, used to distinguish which area they should be used in, were still stored together in the buckets. The way the mops were stored would not allow them to 'air dry'. Staff were unclear which coloured mop was used in high risk areas, as there was no plan for staff to adhere to of which areas should be cleaned when and using what coloured equipment. All these issues increased the potential for cross infection and cross contamination.

● When we visited on day 2 of the inspection none of the mops or buckets had been used, we asked staff if they had cleaned or disinfected any areas of the home, they said they had not. That compounded the situation of no cleaning protocols, as staff had no instruction when and how to clean and disinfect areas of the home.

● We asked the acting manager for the cleaning schedules, but these could not be found. Some carpets were heavily stained and some bedrooms had a stale urine odour. We asked the acting manager about a cleaning and replacement regime for these areas. They indicated there was no plan in place to improve these areas.

● We asked the acting manager for the infection control audit. This could not be found, and we asked the acting manager to urgently undertake an infection control audit to ensure people were protected. That meant there was no planned intervention to improve the environment and this placed people at risk from cross infection and cross contamination.

● We asked the acting manager to send us the training records so we could confirm what infection control training had been undertaken by staff since. They said they could not find any training records. That meant we could not confirm staff had been trained to provide a good service for people.

● We asked the nominated individual to show us the policy and procedure on infection control. They were unable to open these on the computer as access had been stopped. Therefore, staff remained without adequate instruction on how to keep people safe and the home clean and hygienic.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● The system to manage medicines was not safe. We found that staff records for medicines sent from the chemist in their original packaging were not detailed. There was no accurate record kept of how many tablets had been received by staff, when these had begun to be administered to people or how many had been used. We also saw there were missing signatures on the administration charts (MAR). That meant we could not be assured that people actually had their prescribed medicines.

● There was no checks in place around the ordering of medicines. This resulted in some people running out of medicines and as there was no one auditing the medicines administration system this could be for some days before being rectified. Similarly, there was a substantial amount of overstocking of medicines, as staff had regularly requested the same medicines from the GP.

● We asked the acting manager if they had investigated the missing signatures, they said they had been

aware but had not had time to look explore the reasons for the missing signature or overstocking.
● There had been no temperatures recorded for the storage area. We could not be assured medicines were stored at a temperature that ensured they remained potent.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people were assisted to manage their medicines with a view to being independent. One person said, "I would like a medication safe in my room so that I can take them myself."

Temperatures had been recorded for the medicine's fridge. All the recorded temperatures were within the limits set for medicines storage.

Staffing and recruitment:
● People's safety was not fully supported by the provider's recruitment practices. We looked at four recruitment files for staff. None of the four files we looked at contained all of the information required. We could not be assured that all necessary checks had been carried out. This placed people at risk of harm from staff whose employment and background history had not been checked thoroughly.
● One person who lived in the home stated there was not enough staff to ensure they were cared for safely. This person said, "I am supposed to get one to one hours every day. I get max 2 hours per week if I am lucky."

● We asked the acting manager how the staffing hours were compiled. They told us they were decided on people's needs. However, there were few detailed care plans in place that described people's needs adequately.
● There was no detailed system in place to assess how many staff were needed, based on the needs of people. Staff told us there were not enough staff to meet the support needs of people.

Inadequate

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

Inadequate: This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.
- The acting manager was unsure if capacity assessments had been completed for people who had varying capacity.
- The acting manager could not evidence that DoLS applications had been submitted to restrict people's access out of the home.
- Staff we spoke with staff could not confirm they had undertaken MCA training. We could not be sure the staff fully understood the principles of the Act, as none were sure of what they could legally prevent people doing to ensure their safety.
- Staff were unaware of the principal of capacity. This is where people were presumed to have capacity to make decisions unless an assessment was completed and proved otherwise. We could not ascertain all the people who lived in the home had capacity.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had not had their individual needs assessed prior to coming into the home. Needs assessments are necessary to ensure the provider has the correct number of suitably trained staff to care for the person.
- Risks associated with people's care and support had not been assessed which placed people and staff at risk.
- Staff did not provide care and support in line with national guidance or best practice guidelines. For example, for a person living with epilepsy regularly declined their tablet medicine. There were no action plans telling staff what they should do if the person had a seizure.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● People were not cared for by a well-trained informed staff group. One member of staff said, "I have done training on the computer." The staff member went on to say they could not remember what training they had done. Other staff told us they felt they had not had the training they required to support people properly.

● We spoke with the acting manager about the training records, they said they could not find any training records and they were not aware of the content of any training provided to staff. They told us they had started to plan a training programme but could not evidence this.

● The acting manager had not arranged any staff supervision or checked on staff's continued ability to administer medicines competently since being in post. Supervision can be used for staff development and uses an exchange of information to promote change and improvements for people.

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

● People said the choice of meals was restricted and they did not have a choice on what food was offered to them. One person said, "Food wise, there is no choice we have what is on the menu for that day." Another person said, "Staff make my meals for me, I get plenty to eat and drink."

● Some people shopped and catered for themselves with staff assistance. Staff told us they locked all the food away as people would help themselves and use all the food before the next shopping came in.

● People's dietary and cultural needs were met.

Staff working with other agencies to provide consistent, effective, timely care

● Four of the people admitted to the home had the input of a social worker. They were working with the home to ensure suitable accommodation could be found which would assist their reintroduction into the wider community.

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

● The environment had not needed to be adapted as it met the needs of the current people who lived there.

Supporting people to live healthier lives, access healthcare services and support

● People told us they arranged their own or were assisted by staff to access healthcare. One person said, "I make arrangements to see my Doctor myself. I receive the letters and then staff help me keep my appointments." Another person said, "They [staff] come into my appointments with me. They then help me understand what has been said."

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

RI: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity

● We observed people were treated with kindness and compassion by a caring staff group. Interactions with people throughout the inspection showed that people were treated respectfully. Some people were positive about the staff group and the care they offered. One person said, "The staff are caring, ten out of ten for care. However, another person said, "I sometimes find it annoying when staff are playing music / games aloud in the living room when we are trying to watch the TV." Another person said, "Some staff I do not like, and they do not like me, they mostly respond to my wishes. Some of the staff are professional." We passed the information on to the acting manager to follow up.

● We did not see anyone living in the home had the involvement of an independent advocate and there was no evidence of advocate's contact details. We were not assured all those in the service were supported adequately to make informed choices. An advocate can assist people who have difficulty in making their own, informed, independent choices about decisions that affect their lives. One person said, "I do not need an advocate; [named] is my advocate. If I did need and advocate, I could get one."

● Staff had not been trained to recognise people's health or mental health needs. Staff were not trained to spend time with people to discuss their mental health needs and encourage and prompt recovery.

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

● People told us they were involved in reviewing their care plan. However, we could not evidence this as there were no written records of people's involvement or where people had signed to agree their care plan.

Respecting and promoting people's privacy, dignity and independence

● People had the opportunity of a bedroom key to secure their property. We observed staff respected people's privacy and dignity, and heard staff knocking on people's bedrooms before entering and announcing themselves. That demonstrated staff were aware of the need to ensure people's privacy and dignity.

Inadequate

Is the service responsive?

Our findings

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

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Care plans we reviewed were not well detailed, did not include risk assessments and did not provide staff with information based on people's personal centred care needs. Some pre-admission paperwork was included in people's files, but this information was not always included in all the paperwork in the home. For example, one person had allergies to latex, cats, sticking plasters and ibuprofen. However, none of these details were included in the documents that had been produced by the staff. The staff we spoke with was also unaware of the person's allergies.
- There was no evidence of any up to date photographs in people's files, which was necessary in case of an emergency, for example a person going missing from the home. We spoke to the acting manager who stated he would have up to date photographs arranged.
- There was no information about people's past history, likes, dislikes, wishes or aspirations which could provide valuable information to staff where changes in behaviours were evidenced.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- There were no communication passports in place for those who required them. Communication passports are a means of communicating people's support needs, where the person is unable to express those needs verbally or has a cognitive impairment that reduces their ability to communicate.
- We asked the acting manager about the accessible communications standards. The accessible information standards allow staff to formally recognise, assess and record the communication needs of people who have been affected with a hearing and /or sight loss, or communication debility caused by a life changing event. The acting manager was not aware of, nor had instructed the staff in the five steps within the assessment process. That meant people's accessible communication needs had not yet been introduced as part of the assessment process.
- Staff could not demonstrate they were aware of people's individual needs. The senior carer was unaware of the safety measures required when a person was accessing the community. We asked why as the senior, they were unaware of the person's needs, they replied, "Because I am not his key worker." We asked staff if there was a handover of information between shifts and they agreed there was. The lack of knowledge displayed by the senior staff would indicate information was not exchanged between staff on a detailed and consistent basis. We asked for evidence of the handover sheets, but this was not produced at the inspection or forwarded afterwards.
- We spent time and observed people in the public areas of the home. Some sat around watching television

with staff, whilst others remained in their bedrooms. We saw one person was taken out shopping.
● People had no regular planned activities programme which could have developed their self-help skills and provided them with meaningful pastimes. We spoke with the acting manager about the provision of activities in the home. They said the staff supported some group activities, such as special 'carry out' meals and film nights but there was no individual planned activities and any that were done were on an 'ad hoc basis'. That meant people were not supported to follow their hobbies or interests and there was no plan to develop people's self-help skills to support a move to independent living.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people told us they were supported by staff to find education courses that they could attend. Others said they would not or were not ready to find employment. One person said, "I used to go to college, I hope to go back and study computer courses." Another said, "I would like to go back to college. I would like to have a job one day." However, another person said, "I am interested in employment, staff do not help me with this." We mentioned this to the acting manager, who stated they would look into the potential of employment for this person.

Improving care quality in response to complaints or concerns
● People were aware they could make a complaint about the service. One person said, "I have never made a complaint. If I did, I know that my complaint would be investigated properly."
● The provider had no system in place to record complaints. There were no records to demonstrate if the service had received any written complaints. The acting manager said they were unsure what complaints had been made and could not determine where the records were located. We were unable to look at the complaints policy and procedure, as they were not accessible to the acting manager.

This is a breach of Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints.

End of life care and support
● There was no end of life planning with the people in the home or their relatives. We asked the acting manager and senior carer if any discussions were planned, but they stated no plans were in place.

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

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

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

- The provider had not undertaken any governance or audits of the systems used to support people and staff in the home. There were no audits of infection control, medicines, the environment or safety of the home. Temperatures of hot water and freezers were not adequately monitored or regulated which placed people in danger.
- There was no access to any policies or procedures. That meant the staff had no guidance or instruction to keep people safe or operate processes in the home.
- There was no staff training matrix or staff development plan to ensure staff training was planned and staff roles were developed to ensure people receiving care had the correct care and support.
- These were serious failures by the provider to use any adequate governance processes which could have revealed these errors and omissions.
- The provider lacked the knowledge and skills to ensure the safe and effective running of the home, which impacted on the quality and safety of the service offered. Quality assurance and governance were not used effectively to drive continuous improvement in the home.

This was a breach of Regulation 17(a) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- There was a manager registered by the Care Quality Commission (CQC) to undertake the responsibility of ensuring people were cared for and supported safely and in line with current legislation. At the time of our inspection visit, the registered manager had not been at the service for over three weeks and was not providing guidance for the staff. The home was run on a daily basis by an acting manager and senior carer.
- The registered manager had failed to notify us about incidents that involved the people who lived there. We noted several incidents that constituted harm to people, for example one person fell and was admitted to intensive care as an in-patient. None of these incidents had been reported to CQC. We did not have confidence in the registered or acting manager that their knowledge was detailed enough to ensure their legal duties were exercised and we were informed of incidents that had occurred.

This was a breach of Regulation 18 (Registration) Regulations 2009, Notification of incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics

● People who used the service confirmed they were provided with questionnaires to rate how well the staff performed.

● The acting manager said he was aware questionnaires had been provided to people, however, could not find these. This meant we could not be assured they had taken action in response to people's feedback.

Continuous learning and improving care

● People told us there were regular meetings to discuss any issues that had arisen at the home. One person said, "There are house meetings every week / fortnight, I always attend." Another person said, "The meetings are about house rules and food etc."

● Staff said their acting manager was accessible and approachable and dealt with any concerns they raised.

● Staff said they felt confident about reporting any concerns or poor practice to the acting manager or senior care staff.

Working in partnership with others

● The acting manager demonstrated how they worked in partnership with local hospitals, the local authority safeguarding team and other healthcare professionals, however, failed to provide improvements to people's care and environment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to ensure they notified CQC of all incidents that affected the health, safety and welfare of people who use services.

The enforcement action we took:

Notice of proposal to cancel registration

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 care and support plans were not detailed or updated. Reviews of care did not include the person or their relative to ensure the care and support offered met people's needs and reflected their preferences.

The enforcement action we took:

Notice of proposal to cancel registration

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: the assessment of a safe environment; adequate prevention and control of infection; safe administration of medicines and assessment of people's needs.

The enforcement action we took:

Notice of proposal to cancel registration

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 The provider failed to ensure people were held legally within the constraints of the DoLS and

MCA.

The enforcement action we took:

Notice of proposal to cancel registration

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 an effective and accessible system for identifying, receiving, handling and responding to complaints

The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure quality assurance systems were always effective and had not identified the risks and concerns we found during our visit.

The enforcement action we took:

Notice of proposal to cancel registration