Oban House Retirement Care Home

Oban House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oban House Residential Care Home is a residential care home providing accommodation and personal care to up to 30 people. The service provides support to people with age related frailties and people living with dementia. At the time of our inspection there were 24 people using the service.

People's experience of using this service and what we found
People's health and associated risks were not robustly assessed. People's care records did not contain enough information for staff to safely support them. Risk assessments for people who required support with conditions such as, diabetes, epilepsy and Parkinson's disease were either vague or not completed. Risk assessments had not been conducted for people who had catheters. People's weight and the risk of pressure damage to their skin were not routinely assessed and monitored.

People were not always protected from the risk of being supported by unsuitable staff. The provider's recruitment policy was not followed; staff were deployed before recruitment checks had been carried out and appropriate training had been given. The registered manager was unable to demonstrate safe recruitment of staff. One staff member had an out of date visa and no references on file.

People were at risk of accidents due to environment checks not being completed to identify and mitigate risks. People were able to access areas of the service which were in need of repair. A bathroom and toilet were both in disrepair and were being used to store items. Storage was not orderly, and items posed a trip hazard to people. The registered manager was not aware of all accidents and incidents, healthcare professional advice was not always sought for people following falls. Trends analyses were not completed to learn from and prevent further accidents and incidents.

People were not always protected from the risk of abuse; the provider's policy did not contain details of local safeguarding arrangements and staff were not aware they could raise concerns with the local authority. Not all staff had received safeguarding training, new staff had not always received this training as part of their induction package.

People and their relatives had no formal processes to feedback on the service. Surveys had not been routinely carried out and meetings had not taken place. Quality assurance audits had not been conducted to identify shortfalls at the service. The medicine audit had gone missing at the time of our inspection.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The registered manager had not assessed any person's mental capacity, they told us everybody had capacity although people openly told us they struggled with their memories. People were subject to some restrictions, the registered manager told us this was to ensure people's safety, however, restrictions were not documented with a rationale to why they were necessary.

People mostly had access to healthcare services. Due to the lack of analyses and investigation to accidents and incidents, there were missed opportunities for staff to seek healthcare professional advice to support people. The registered manager gave examples where staff had worked well with professionals. We saw people had access to visiting chiropodists and opticians. At the time of our inspection, people were receiving COVID-19 boosters. A visiting healthcare professional told us, "I have found staff to be professional and friendly with the residents at all times."

People's care plans did not contain person-centred information about how they wished to be supported. There was little evidence of people's involvement when planning their care. However, we observed person-centred and kind interactions between staff and people.

People and their relatives told us staff were kind and considerate. One person told us, "I'm quite, happy, lovely staff, no complaints." A relative said, "They look after [person] well."

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

Rating at last inspection
The last rating for this service was good (published 28 February 2020).

Why we inspected
We received concerns in relation to the management and reporting of injuries to people, and the storage and disposal of medicines. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

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

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

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

Enforcement
We have identified breaches in relation to assessing safety to people's health risks and the environment, infection control, staffing, recruitment, safeguarding and good governance.

We have made a recommendation about the induction for new staff.

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 well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Oban House Residential 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 undertaken by 2 inspectors.

Service and service type
Oban House Residential 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. Oban House Residential 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.

Notice of inspection
This inspection was unannounced. We visited the service on 18 and 20 April 2023, both visits were unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from Healthwatch, Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we observed support people received throughout the day. We spoke with 10 people who used the service about their experience of the care provided and 2 relatives of people who use the service. We sought feedback from 4 health care professionals who regularly visited the service. We spoke with 8 members of staff including the registered manager, deputy manager, care staff, housekeeping staff and kitchen staff.

We reviewed a range of records. This included 9 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- Risks were not managed safely. Prior to our inspection, we received concerns regarding unexplained bruising to people and the record keeping of injuries.
- One person told us they fell regularly and showed us some bruising. The registered manager told us the person did not fall and there was no record of their falls in the accident/incident file. Upon review of the person's care records, completed body maps and entries of injuries were found. Two of the incidents included head injuries; medical advice had not been sought and follow up observations were not documented in accordance with good practice guidance. The registered manager told us there was no policy for staff to follow in this instance, however, was arranging for one to be written. Without clear guidance, people were at risk of not receiving medical attention when required.
- There were few reported accidents and incidents contained in the accident/incident file. For those documented, there was no process to analyse trends and learn lessons when things went wrong. On the first day of our inspection, a person had an unwitnessed incident and was found to be on the floor; on the second day of our inspection, an incident report had not been completed. The registered manager told us staff did not document such incidents. Without robust documentation, investigations and appropriate follow up actions, people were at risk of continual incidents.
- Risks to people's health had not been robustly assessed. Health conditions, such as, diabetes, epilepsy and Parkinson's were not fully assessed to guide staff on how to safely care for people. For example, the risk assessments for a person with epilepsy did not guide staff on the type of seizures they may experience and at what point staff should contact emergency services if the person was experiencing a seizure. Without detailed information, people were at risk of not receiving appropriate healthcare professional advice.
- Assessments and care plans for people living with diabetes did not consider associated risks to people's eye or foot health. Care plans in respect of diabetes lacked guidance for staff on how to recognise the signs of when people's blood sugars became unstable. A person's care plan instructed staff to take their blood glucose reading twice a day, there was no guidance of what the safe range of sugar levels should be, staff had not taken the person's blood glucose readings. The registered manager told us this was completed by the district nurses; the person's care plan had not been updated to reflect this.
- The fire risk assessment for the service had not been reviewed since May 2019. Door wedges were being used to prop people's bedroom doors open. On the first day of our inspection, the fire alarm sounded, some doors closed automatically but doors to people's bedroom remained open. In the event of a fire people would not be protected by a fire door. We raised our concerns with the registered manager who took action to ensure that the use of door wedges on fire doors was immediately reviewed. Risk associated with people smoking cigarettes were not assessed, this left people at potential risk of burns.
- The deputy manager's office was undergoing refurbishment. On the first day of our inspection, the office door was propped open by wood, a fire extinguisher, and an open baby gate; debris and equipment had

been left out which posed as a potential trip hazard. A risk assessment had not been completed for the works and people were able to access the area. There were no assessments of the environment to identify risks and no health and safety checks completed. This left people at risk of accessing unsafe areas.

There was a failure to ensure care and treatment was provided in a safe way or risks to people had been mitigated. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Areas of the service were not able to be thoroughly sanitised. For example, a toilet frame had paint flaking from it exposing rust. Grab rails were unable to be fully cleaned as personal protective equipment (PPE) storage was attached to the rail by zip ties. This left people at potential risk of cross infection.
● We were somewhat assured that the provider was using PPE effectively and safely. Staff were wearing PPE when supporting people with personal care, however PPE was not stored appropriately.

There was a failure to ensure appropriate infection control measures to protect people. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● People were able to welcome their friends and families into the home and to go out with them if they wished.

Systems and processes to safeguard people from the risk of abuse
● Processes were not in place to protect people from the risk of abuse. Most staff had received training and understood how to recognise safeguarding concerns. However, staff were not aware of the external organisations they could contact if they were concerned about people. The provider's safeguarding policy had not been completed to include local safeguarding arrangements and the local authority's contact details. Without clear processes, people were at potential risk of concerns not being appropriately escalated and investigated.
● There were restrictions in place which were not in support of people's rights. For example, one person had requested to help in the laundry but were told they were not permitted to do so. The registered manager told us this was for the person's safety and had not considered a less restrictive option to meet the person's wishes. The registered manager had not recognised this as a restriction to the person.
● In the provider's Provider Information Return (PIR) the registered manager had noted 20 people had restraints or restrictions to their care and support, however, there was no mental capacity assessments to demonstrate what the restrictions were and why they were necessary or proportionate.

The provider did not ensure staff had access to procedures and guidance for raising and responding to

concerns of abuse. The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from restrictions. This is a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe. One person said, "I feel safe. It's welcoming and everyone is friendly." A relative told us, "My relative feels comfortable, in that they at their ease, they don't feel threatened or vulnerable or at risk."

Staffing and recruitment
● Staff recruitment was not carried out safely. Staff had not always completed application forms, and references were not routinely applied for prior to commencing employment. The registered manager was unable to evidence recruitment documentation for one staff member. The registered manager sent us an email with the information. The staff member had commenced work in January 2023 however, all their recruitment documentation including references were contained on forms dated April 2023.
● Checks on staff's right to work within the UK were not being routinely carried out. Another staff member had commenced employment in January 2023, however, the visa contained in their recruitment file had expired in November 2021. The registered manager told us they had not kept interview notes for this person and there were no references on file for them. Without robust checks, there was a risk of people being supported by unsuitable staff.
● The registered manager had not considered risks associated with staff working directly with other family members. There was no policy or risk assessment in place to support decision making of family members working together.

The provider had failed to operate robust recruitment procedures and ensure that relevant pre-employment checks for new staff were undertaken. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's every day needs. We observed staff were busy in the mornings but were able to spend more time with people in the afternoons. The provider did not use a dependency tool to ascertain staffing levels to assure themselves levels were appropriate. We received mixed feedback about staffing levels. One staff member commented, "There are enough staff." Another staff member said, "There's not enough staff here." People also provided mixed feedback. Comments included, "I always know when they are short. They are rushing around and you're late being seen to." Another person told us staff quickly attended to call bells.

Using medicines safely
● Medicines were mostly managed safely. Our inspection was in part prompted by concerns regarding the storage and disposal of medicines. When we arrived at the inspection, a person's topical creams were left out in a communal area, the labels included confidential information and there was a potential risk of the creams becoming misplaced. A staff member noticed an hour later and took the cream to the person's bedroom.
● Staff told us they had received medicine training, although the training matrix did not reflect this. Some staff told us their competency was assessed before being permitted to administer medicines to people. We could not be assured of the validity of the competency assessments; the handwritten dates on the assessment forms pre-dated the document format update which was April 2023. The registered manager told us they would be reassessing all staff for their competency for administrating medicines.
● People received their medicines as prescribed, where people required medicines that needed to be administered at specific times, this was met. We observed people being administered their medicines in line

with their preferences. When discussing medicines, a person said, "I know exactly what I should have, and they give me the right medication."

● Medicines were ordered and disposed of safely. A new medicine cupboard had been installed, medicines were well organised and clearly labelled. The registered manager and their deputy ordered and checked in medicines together to avoid error. The registered manager had recently appointed a local pharmacy in response to errors and delays from their previous pharmacy.

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.

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

- People's needs were not always assessed using nationally recognised tools in line with standards, guidance and good practice in care homes. People's weights were not being consistently taken and effectively analysed; body mass indexes (BMIs) were not calculated, and malnutrition universal screening tools (MUST) scores were not completed. MUST is used to assess people's risk of malnutrition, without regular assessment, people were at potential risk of malnutrition not being identified in a timely way.
- Waterlow assessments had not been fully completed to include people's BMI and MUST scores. Waterlow tools were last completed in December 2022, people who were admitted after that date had not been assessed. The Waterlow tool identifies where people are at risk of pressure damage to their skin. Without accurate and regular completion of the tool staff were unable to assess the risk of people developing pressure damage to put preventative measures in place.

There was a failure to ensure care and treatment was provided in a safe way or risks to people had been mitigated. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the registered manager told us they had assessed people's MUST scores and updated Waterlow assessments.
- Prior to people moving to the service, they had opportunities to look around and speak with other people. The registered manager undertook pre-admission assessments by telephone with people's relatives. Where information was available from the local authority of hospital, the registered manager considered the information during the assessment process. One relative told us, "Before my relative went in, there was a comprehensive questionnaire which the home read and confirmed."

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

- People's needs were not always met by the adaptation of the service. Areas of the service were in disrepair. A toilet and a bathroom were not in use, towels and buckets were left on the floor posing as a trip hazard. Both rooms were unlocked, accessible to people and were used to store items. The attic area was accessible to people and contained unused equipment and archived files posing a trip hazard. We sought urgent assurances during our inspection, the registered manager secured these areas.
- There had been limited consideration to the environment to support people living with dementia. People's bedrooms were not identifiable with pictorial or written signage. Without this, people may need to rely on staff to support them to move around the service.

● Corridors and landing areas were not free from clutter during both days of our inspection. On one landing, a curtain had fallen from the rail and was left on the floor. At the end of one corridor 3 unused televisions were stored. A broken chest of drawers remained outside a person's bedroom with 2 stained pillows stored on top of it. A commode and computer monitor were stored on another landing along with pictures leant against the wall. These had not been identified as potential hazards.

There was a failure to ensure risks to people had been mitigated. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the registered manager told us they were conducting regular checks on the environment. A schedule of works were due to be completed to address the concerns found at our inspection.

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.

● The registered manager had not completed mental capacity assessments with people and did not demonstrate a working knowledge of the MCA. They told us all people living at the service had mental capacity. Despite this, the registered manager had served papers from the Court of Protection on one person. The Court of Protection make decisions on financial or welfare matters only for people who lack mental capacity.
● Some people shared with us they had problems with their memories, part of the MCA is regarding retention of information. One person told us they had lived at the service for "about 3 days" they had lived at the service for 5 years. During our inspection, a person sustained an unwitnessed incident and was found to be on the floor; they could not recall the incident after an hour. The registered manager had not considered the retention of information when deeming people had mental capacity.
● There had been no DoLS applications made in the service although some restrictions were in place. Staff did not demonstrate an understanding of the MCA although some had received the training. One staff member told us they thought some people had a DoLS authorisation in place but was unable to say who or what this would mean.

The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from restrictions. This is a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff had not always completed training relevant to their role. The registered manager identified gaps in training and had started to roll out a programme of training to prioritise mandatory training. However, when asked, staff were unable to demonstrate what they had learned in subjects, such as, safeguarding and the MCA.
● New staff were not offered a comprehensive induction programme, for example, the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. The registered manager told us, "Induction is shadowing staff for a few shifts and the senior staff will report back and give me their feedback." New staff joined the existing training programme, which means they may not always receive training in a timely way.

The failure to ensure staff had the appropriate training and supervision to ensure people's needs were met is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff supported people with a wide range of needs, training was planned in response to these needs. For example, catheter care and stoma care following people being admitted into the service with this need. One staff member said, "[The trainer] is thorough and does demonstrations for things like moving and handling. Even if we don't have clients there using equipment, [the trainer] would go through everything with us, we have experienced what they (people) feel."
● Staff received supervisions which most told us were relevant and supportive.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff mostly worked with other agencies to provide effective care. Where incidents and accidents had not always been robustly documented and handed over, there were missed opportunities to liaise with professionals to mitigate the risk of reoccurrence.
● The registered manager gave an example where occupational therapists had assessed people for walking aids and specialised wheelchairs. They told us, "When [person] was assessed and measured (for a wheelchair) we begged for [person] to be prioritised. They managed to get it in time. [Person] cried as they were so happy. To bring [person] to the lounge on their birthday was lovely. Otherwise [person] would be in a normal wheelchair which they could only be in for an hour."
● During the inspection healthcare professionals were visiting the service to provide COVID-19 boosters to people. People were visited by chiropodists and an optician visit had been planned. A staff member told us the registered manager was sourcing a dentist to visit people in the service. A visiting healthcare professional told us, "The staff are very good at sending through (referrals) and noticing changes in the health of their residents quickly."

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to maintain a healthy diet and fluid intake. Menus were designed around people's preferences and alternative dishes were available.
● Kitchen staff were knowledgeable about people's dietary requirements, although care records did not always reflect people's current need. One person's care record stated they were coeliac and to avoid foods containing lactose. The care plan did not detail information to avoid foods containing gluten. The person was served food which contained lactose and gluten, staff told us the person was able to tolerate all foods and the care plan was out of date.
● We received positive feedback regarding the food, people told us they enjoyed the meals provided. One person told us, "The food is pretty good, the cook has a high standard. I get what I want." We observed lunch

time to be relaxed and staff offered people choices of where they wished to eat.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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 were not clear about their roles and regulatory responsibilities. The registered manager had not prioritised the safety of people when planning building works. For example, the refurbishment of the deputy manager's office had been prioritised over repairs of bathrooms and toilets. We fed this back to the registered manager who told us they would devise a service improvement plan to ascertain priority, dates of completion and responsibilities. They said, "From my interview until I started, I didn't realise the amount of work needed."
- There were no quality assurance processes in place to highlight shortfalls in people's care records, such as, health needs and associated risks. The registered manager told us their deputy had been rewriting care plans since November 2022, however, there had been no checks to ensure they were appropriate, comprehensive, and up to date. There was an absence of managerial oversight of people's weight and their risk of malnutrition. Records completed by staff had not been identified as lacking information. One person's fluid intake record indicated they had consumed only 200 mils of fluids in a day on multiple occasions.
- Governance processes failed to ensure environmental risks in were assessed and mitigated. There were no checks to safeguard people from potential hazards such as, the risk relating to fire or accessing unsafe areas. Audits had not been completed to ensure the cleanliness of the service. We fed this back to the registered manager who said they will be conducting daily walk rounds of the service and would document and address shortfalls.
- The absence of systems to monitor the quality of the service and provide effective managerial oversight did not allow for actions to be taken to drive improvements and meet regulations. It was not identified recruitment files lacked the information required to meet our regulations.
- People's confidential records and records relating to the running of the service were not always kept securely. The attic area was accessible and contained open boxes of people's care and medicine records. The registered manager told us they had quality assurance processes for medicines. On both days of our inspection, they were unable to locate the audits.
- Accidents and incidents had not always been documented; therefore, openness was not always demonstrated. The registered manager told us people had not experienced accidents and incidents, however, documentation and our observations contradicted what we were told. The provider could not be assured all accidents and incidents had been reported to appropriate bodies and the duty of candour had

been acted upon for reportable safety incidents.
● The provider visited the service regularly and documented their visit. The visits did not identify any concerns found at this inspection.
● The registered manager failed to demonstrate understanding of their responsibilities with regulatory and legislative requirements. The registered manager had not submitted any notifications to CQC about significant events in the service. The registered manager was not fully aware on when they should submit notifications to CQC and told us in their previous roles this was always completed by the provider. The registered manager subsequently submitted statutory notifications to CQC immediately following our inspection and told us they would improve their awareness.

The provider failed to ensure there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. The provider failed to maintain secure, accurate, complete and contemporaneous record in respect of each service user. The provider failed to maintain records in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● The culture of the service was not always open and person-centred. Some people were subject to restrictions; one person told us they wanted to go out more but were told they could not in case they fall. They told us, "They treat me like a baby. They don't want me to have accidents because they don't like filling in the forms."
● The service did not always promote a positive and inclusive culture which involved people. Staff were unable to evidence how they included people when planning their care. Care plans lacked person-centred information and did not reflect people's needs and the support provided by staff.
● We observed a handover, staff referred to people by their room numbers and information was limited, for example, 'slept well' and 'pad changed.' A staff member told us people's actions were sometimes spoken of unkindly during handover. For example, if a person had been incontinent, some staff would refer to this is a derogatory way. They said the registered manager had addressed this and there were some improvements. The registered manager told us they were working with staff to ensure people are referred to by their names.

● The registered manager was unable to evidence how they sought the views of people and relatives or acted on feedback. The registered manager showed us some surveys which had been completed by people with the assistance of staff. Feedback surveys were undated, and the results had not been analysed. There had been no meetings held for people or relatives.
● The registered manager had been in post since November 2022. They told us there was some disharmony between themselves and some staff members due to the introduction of new procedures. We received mixed feedback from staff about the registered manager. Comments included, "If I was concerned, I wouldn't go to [registered manager]. You wouldn't get anywhere with them. You hand things over and write things in the book; nothing comes of it." And, "Some staff aren't taking change very well. It's difficult for [registered manager] to manage."

The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been one staff meeting held. The minutes of the meeting covered a wide range of topics and staff were invited to contribute. For example, one staff requested torches in the event of a power cut, a person's call bell usage was also discussed. Staff's suggestions and opinions were listened to by the registered manager.
● The registered manager told us they spent time with people. One person told us, "They (registered manager) would answer any questions we have. We don't have residents' meetings as such. We sit as a group and chat. Put the world to rights."
● People's relatives told us they felt comfortable to approach staff and management if they had any comments or suggestions. One relative told us, "I do speak with the staff on a regular basis to check if [loved one] need extra clothes. I have not needed to discuss anything in terms of the management."
● People and their relatives spoke positively of the staff, comments included, "All of the staff are friendly, proactive. They go about their business in a quite professional and capable way. No fuss, nothing is a problem. They have excellent in looking after my relative." And, "I am very happy here, staff are very kind." We observed some kind interactions between staff and people, we noted staff offering people choices, such as, what they wished to drink.

Working in partnership with others
● The service mostly worked in partnership with professionals. Where people had health needs, staff worked with professionals to ensure the needs were met. One person told us they had some complications with their catheter and were trailing a new type of bag. The person told us they were pleased to have a review with the catheter nurse and was being supported by staff.
● We received mixed feedback from visiting healthcare professions. We were told, "They (staff) are open to suggestions and follow through any actions. I have never heard of any issues. They refer in a timely way. They are responsive if a patient needs to be seen. I've not met the manager, the main people I deal with are team leaders and seniors." Further comments included, "Trying to gain access to the property can be difficult. Trying to find staff, sometimes it's difficult locating them."
● The registered manager told us following a visit from the fire and rescue service, they have updated people's person emergency evacuation plans (PEEPs) based on the feedback provided. We saw PEEPs were contained on one page and provided information about people's mobility and assistance required in the event of an emergency.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure staff had access to procedures and guidance for raising and responding to concerns of abuse. The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from restrictions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate robust recruitment procedures and ensure that relevant pre-employment checks for new staff were undertaken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure staff had the appropriate training and supervision to ensure people's needs were met.

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 There was a failure to ensure care and treatment was provided in a safe way or risks to people had been mitigated. There was a failure to ensure appropriate infection control measures to protect people.

The enforcement action we took:

Warning Notice to be served

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 there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. The provider failed to maintain secure, accurate, complete and contemporaneous record in respect of each service user. The provider failed to maintain records in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity. The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

The enforcement action we took:

Warning Notice to be served