Alcyone Healthcare North East Ltd

Baedling Manor

Inspection report

Front Street West
Bedlington
Northumberland
NE22 5TT

Tel: 01670335119
Website: www.alcyonehealthcare.co.uk/

Date of inspection visit:
07 January 2021
13 January 2021

Date of publication:
17 November 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Baedling Manor is a residential care home providing accommodation and personal care to up to 54 older people. At the time of this inspection 41 people were living at the home and in receipt of care and support.

People's experience of using this service and what we found
A robust safeguarding system was still not in place following our previous inspection. Staff said they would report any concerns to the management team, but we found these safeguarding concerns were not always reported to the appropriate external agencies in a consistent way.

Safe and effective infection control systems and procedures were not fully in place to ensure people were protected from the risk of infection. Government guidance relating to safe working practices including the appropriate use of Personal Protective Equipment [PPE] and hand hygiene, was not always followed by staff. This placed people at risk of infection which is of particular concern during this time of a national pandemic.

Medicines were not managed safely. There were inaccuracies and omissions with the administration and recording of medicines. Medicines administration records did not always demonstrate that medicines had been administered appropriately and as prescribed.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. Although policies and procedures were in place, systems were not always followed.

Staff training was not up to date. There were gaps in the skills and knowledge of staff across multiple areas of the service. The provider had stopped using their former training agency in October 2020. They had arranged to use a new training company from January 2021. A training plan was in place.

People we spoke with told us they were happy and enjoyed living at the home. Most relatives also spoke positively about the caring nature of the care staff. The language used by some staff in care records did not always promote people's dignity. We have made a recommendation that the provider ensures best practice guidance is followed with regards to the language and terminology used within care records.

An effective complaints system was not in place. Several relatives stated that they had not received a response to their complaint.

People's social needs were met. An activities coordinator was employed. She spoke enthusiastically about meeting people's social needs. Due to the current Covid-19 pandemic, people had not been able to go out into the local community; activities had therefore taken place in the home.

Several staff described a closed culture at the home where they did not always feel able to raise issues and concerns. We received concerns from a number of sources about the manner and approach of the director which they said did not always reflect the ethos and values of the service.

A system to ensure regulatory requirements were met was still not in place. We identified shortfalls in many areas of the service including the assessment of risk, infection control, safeguarding people from the risk of abuse, Mental Capacity Act [2005], training, the management of complaints and governance/management oversight. In addition, an effective system to ensure that all notifications were submitted to the CQC in a timely manner was still not fully in place. This failure to notify the CQC of incidents and other matters in line with requirements meant people were exposed to a risk of harm as there had been no overview by CQC to check whether the appropriate actions had been taken.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 11 September 2020). There were multiple breaches of regulation identified at that time. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, sufficient improvement had not been made and the provider remained in breach of the regulations.

Why we inspected
Prior to our inspection we received concerns in relation to safeguarding, staffing, medicines, complaints and the governance of the service. A decision was made for us to inspect and examine those concerns. The inspection was also carried out to check that the provider had followed their action plan and confirm they now met legal requirements.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to the coronavirus (Covid-19) and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the need for consent, safe care and treatment, safeguarding people from abuse and improper treatment, staffing (training), receiving and acting on complaints and good governance of the service at this inspection. In addition, we also identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 namely, Notification of other incidents.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or varying the conditions of their 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Baedling Manor

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors, a medicines 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.

Service and service type
Baedling Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission. The manager was in the process of registering with CQC to become a registered manager. The provider, Alycone Healthcare North East Ltd, is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with four people who used the service, eight relatives, the nominated individual and staff including the manager, deputy managers, day and night care workers, the activities coordinator and the head chef. We also spoke with two health and social care professionals. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included people's care records, medicines records and information relating to staff recruitment and training. A variety of records relating to the management of the service, including policies and procedures were also examined.

After the inspection
We continued to seek clarification from the manager to validate evidence found. We looked at further information which they sent to us electronically. We spoke with three health and social care professionals and five relatives. We provided feedback to the local authority about our inspection findings.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

At our previous inspection systems and processes were not operated effectively to identify, investigate and respond to allegations of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found effective action had not been taken to improve and the provider remained in breach of Regulation 13.

- An effective safeguarding system was still not in place.
- Most staff had not received safeguarding adults training in the past 12 months which meant they had not received refresher training in this topic following concerns raised about safeguarding practices and procedures at our last inspection published in September 2020.
- Staff said they would report any concerns to the management team, but we found these were not always reported to the appropriate external agencies in a consistent way which meant people were not protected from harm and abuse when they should have been.

The above shortfalls constituted an ongoing breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our previous inspection there was a failure to properly assess, monitor and mitigate risks to the health and safety of people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found effective action had not been taken to improve and the provider remained in breach of Regulation 12.

- An effective system to manage risks was still not in place.
- Risks relating to choking had not been properly assessed and monitored. Two people were receiving food of consistencies which should have been avoided to reduce their risk of choking.
- Equipment to support the safety and wellbeing of an individual had not been obtained in a timely manner.
- Several people had been involved in a number of behavioural incidents that presented a risk of harm to themselves or others. There were no clear strategies in their care records about how to minimise the risk of these incidents.
- Lessons had not been learnt from the previous inspection.

The above shortfalls constituted an ongoing breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the second day of the inspection, the nominated individual informed us that the equipment to support the safety and wellbeing of the individual referenced above was going to be purchased.
● Routine safety checks were carried out in relation to the premises and equipment. There had been an improvement in fire safety. Regular fire drills were now carried out.

Preventing and controlling infection
● A safe and effective infection control system was not fully in place to ensure people were protected from the risk of infection.
● Government guidance relating to safe working practices including the use of PPE and hand hygiene was not always followed by staff.

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

● On the second day of the inspection, action was being taken to address the concerns identified relating to infection control. The nominated individual wrote to us and stated, "No resident in Baedling Manor Care Home has contracted Covid-19 since early June 2020."

Using medicines safely
● Medicines were not managed safely. There were inaccuracies and omissions with the administration and recording of medicines. Medicines administration records did not always demonstrate that medicines had been administered appropriately and as prescribed.

The above shortfalls constituted a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to maintain appropriate and complete records in respect of the management of medicines is also a breach of Regulation 17 (Good governance) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our previous inspection staffing levels at the home were not always suitable to meet the needs of the people who lived there. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Action had been taken to improve and the provider was no longer in breach of this regulation in relation to this key line of enquiry.

● There were enough staff on duty on the days of the inspection to meet people's needs. The manager stated that they aimed to provide staffing above the minimum dependency scores and had recruited several new care staff to achieve this. They had reduced the number of agency staff used since the last inspection.
● Safe recruitment procedures were followed. The provider's arrangements for the safe recruitment of staff had improved. Sufficient information was sought prior to appointments to ensure staff were suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection care and support was not always provided with the consent of the relevant person. Staff did not follow current legislation and guidance when obtaining consent or making decisions on behalf of people who lack the mental capacity to do so for themselves. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found effective action had not been taken to improve and the provider remained in breach of Regulation 11.

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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Processes were not always followed correctly to ensure that people's rights were upheld and decisions were made in the best interests of people who lacked the mental capacity to make specific decisions. This included decisions such as moving bedrooms and the use of sensor alarms to make sure the least restrictive option was considered in the first instance.
- An effective system to monitor DoLS authorisations and outcomes was not fully in place to ensure any conditions on authorisations were followed and met.

The above shortfalls constituted an ongoing breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our first day of this inspection, action was being taken to address the above shortfalls. Decision specific mental capacity assessments were being completed. The manager told us that a monthly system to monitor the status of DoLS applications was going to be put into place.

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

At our last inspection the management team had not made sure the systems in place had been effectively managed to ensure care was delivered in line with standards, guidance and the law. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found effective action had not been taken to improve and the provider remained in breach of Regulation 17.

● An effective system was still not in place to ensure best practice guidance was followed when assessing and providing care. For example, we identified shortfalls relating to infection control, medicines management, MCA, dementia care and ensuring people received a safe and suitable diet.

The above shortfalls constituted an ongoing breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection an effective system to ensure staff were suitably trained was not in place. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found effective action had not been taken to improve and the provider remained in breach of Regulation 18.

● Staff training was still not up to date. There were gaps in the skills and knowledge of staff across multiple areas of the service such as, safeguarding people from the risk of abuse, infection control, MCA awareness, dementia care and modified textured diets.

The above shortfalls constituted an ongoing breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had stopped using their former training agency in October 2020. They had arranged to use a new training company from January 2021. A training plan was in place.
● Staff supervision had not been routinely carried out to ensure their competence was maintained. The manager had identified this shortfall prior to our inspection and supervision and appraisal meetings were being carried out.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always provided with a suitable diet to meet their needs and ensure their safety. Two people were given foods which the speech and language therapist had stated should be avoided.
● An effective communication system between care and kitchen staff was not fully in place to ensure kitchen staff were aware of people's dietary needs.

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

● People spoke positively about the meals they received. We observed staff supported people in a calm unhurried manner with their meal.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● A system to ensure people received consistent, effective and timely care was not fully in place. Equipment which a health and social care professional had deemed important for the health, independence and wellbeing of an individual had not been obtained. In addition, the advice from the speech and language therapist had not always been followed in relation to two people's diets.

The above shortfalls constituted a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most health and social care professionals spoke positively about the home. One health professional praised staff for their organisation and support which had enabled people and staff to receive their Covid-19 vaccination.

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

● The home was suitably adapted and designed to meet people's needs.

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 the last comprehensive inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

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

- Due to the concerns identified during the inspection, we could not be assured that people received a high-quality, compassionate and caring service. We have taken this into account when rating this key question.
- Some staff were more confident and skilled than others when communicating and interacting with people who had a dementia related condition.
- People we spoke with told us they were happy and enjoyed living at the home. Most relatives also spoke positively about the caring nature of the care staff team. Comments included, "They are very kind and caring staff" and "Going into Baedling Manor was like going into [relative's] home – very comfortable and the staff are so friendly." However, we received concerns from a number of different sources about the actions and communication style of the director of the company, who it was felt did not always exhibit caring values towards them.

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

- Processes were not always followed correctly to ensure people's rights were upheld. The correct individuals were not always involved when making important decisions such as moving rooms if people lacked the mental capacity to make the decision themselves.

The above shortfalls constituted an ongoing breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- People's privacy, dignity and independence was not always fully promoted. There had been a delay in obtaining equipment for one person to promote their independence. A health and social care professional told us, "I believe if they had the right chair and the commode it would have had a positive impact upon their behaviours."
- The language used by some staff in care records did not always promote people's dignity. We viewed documentation which included language such as, "about to kick off."

We recommend the provider ensures best practice guidance is followed with regards to the language and terminology used within care records.

Requires Improvement

Is the service responsive?

Our findings

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

At the last comprehensive inspection this key question was rated good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- An effective care planning system was not fully in place.
- We identified shortfalls in care records relating to medicines, infection control, the management of risk, supporting people with distressed behaviours and the MCA. These shortfalls meant people were at risk of receiving unsuitable or inconsistent care because staff did not always have clear guidance about how to support people's specific individual needs.

The above shortfalls constituted a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had changed from electronic care plans to a paper-based system. Staff explained this had been a positive change. Action was being taken to improve the level of detail contained within care plans.

Improving care quality in response to complaints or concerns

- An effective complaints system was not in place. Several relatives said they had not received a response to their complaint. This was not in line with the provider's complaints procedure.
- Staff explained the provider had told them any complaints relating to fees had to be sent to head office. The manager said they were not sure how complaints which were sent to head office were dealt with because no documentation about these or the actions taken were available to staff at the home.

The above shortfalls constituted a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- The provider was meeting the requirements of the AIS. The manager told us that information would be available in different formats if this was required.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
● People's social needs were met.
● An activities coordinator was employed. They spoke enthusiastically about meeting people's social needs. Due to the current Covid-19 pandemic, people had not been able to go out into the local community; activities had therefore taken place in the home.
● The provider was looking at visiting procedures so that people could see their relatives safely during the pandemic.

End of life care and support
● End of life care was provided at the home. Staff worked with members of the multi-disciplinary care team to ensure people's needs were met at this time. We spoke with one relative whose relative had recently died at the home. They wanted to provide feedback about the care their relative had received. They told us, "The staff were absolutely amazing with [relative], I cannot praise them enough. They couldn't do enough for [relative] or us. The staff were on the ball and any signs of discomfort they got onto the district nurses. They were really compassionate - wonderful. I really thought they felt the pain with me when [relative] died, I had sympathy cards from the staff. On the day of the funeral the Hearse drove past Baedling Manor and all the staff were outside as a gesture of respect. I cannot thank them enough."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. 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

At our previous inspection an effective system to monitor the quality and safety of the service was not in place. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection effective action had not been taken to improve and the provider remained in breach of Regulation 17.

● A system to ensure regulatory requirements were met was still not in place. The provider's governance system was still not robust enough to identify shortfalls in quality and safety and ensure timely action was taken to address these.
● We identified shortfalls in many areas of the service including the assessment of risk, infection control, the management of medicines, safeguarding people from the risk of abuse, MCA, training, the management of complaints and governance.
● The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 are the minimum standards below which care should never fall. The provider's failure to meet these regulations meant that people received a level of care that did not meet relevant legal requirements.
● Lessons had not been learnt from our previous inspection published in September 2020 as not enough effective improvement had been made, and further breaches of relevant regulations were identified.

The above shortfalls constituted an ongoing breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● An effective system to ensure that all notifications were submitted in a timely manner was still not fully in place. This failure to notify CQC of incidents and other matters in line with requirements meant people were exposed to a risk of harm as there had been no overview by CQC to check whether the appropriate actions had been taken.

The above shortfalls constituted an ongoing breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

● There had been four managers employed at the home within the past 12 months. The current manager

was going through the process of registering with CQC.

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; 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; Working in partnership with others

At our last inspection the provider had missed opportunities to improve the service following complaints and feedback they had received. In addition, some individuals were not confident that the provider would be open and honest if something went wrong. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found effective action had not been taken to improve and the provider remained in breach of Regulation 17.

● A small number of staff described a closed culture at the home where they did not always feel able to raise issues and concerns.
● We received concerns from a number of sources about the manner and approach of the director which they said did not always reflect the ethos and values of the service.
● Several relatives contacted us following our visits to the home to highlight issues which they had raised with the director but had not received a response to their concerns.
● Collaboration and communication with external organisations was not always effective. Important safeguarding information had not always been shared with the local authority safeguarding adults team for their assessment and investigation as appropriate. In addition, equipment which health and social care professionals had deemed important for the health, independence and wellbeing of one individual had not been obtained.

The above shortfalls constituted an ongoing breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The nominated individual contacted us following our inspection and stated, "The home has undergone considerable change in management teams since July 2020, with the current team in place since September 2020. Additionally, the home has had considerable staff turnover as well. This has impacted on the home's consistency of approach." They explained that the roles and responsibilities of management/provider staff had been reviewed and defined and said, "I believe this structured approach will provide a clarity of focus going forward and avoid misunderstandings."
● The nominated individual told us that work was ongoing to improve the culture at the home. They acknowledged that this was something which required time and a consistent approach.

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 Notifications of notifiable incidents that occurred at the service had not been made to CQC in line with legal requirements. Regulation 18 (1).

The enforcement action we took:

We did not proceed with enforcement action in relation to the provider's failure to inform CQC of notifiable events at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Processes were not always followed correctly to ensure that people's rights were upheld and decisions were made in the best interests of people who lacked the mental capacity to make specific decisions themselves. Regulation 11 (3).

The enforcement action we took:

On 12 February 2021, we issued the provider with a notice of proposal to cancel their registration with CQC. The notice of proposal was adopted, and a notice of decision was issued on 16 April 2021 to cancel the provider's registration. The provider had an opportunity to appeal to the first-tier tribunal court which they did, but subsequently withdrew their appeal in November 2021. Therefore, we have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment An effective system was not in place to assess, monitor and mitigate risks relating to the health and safety of people. Medicines were not managed safely and a system to assess, prevent, detect and control the spread of infection was not fully in place. Regulation 12 (1)(2)(a)(b)(f)(g)(h).

The enforcement action we took:

On 11 January 2021, we issued the provider with a notice of decision to impose urgent conditions relating to infection control upon their registration. On 13 April 2021, we imposed additional urgent conditions

upon the provider's registration to help ensure people's safety.

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 Processes were not always followed correctly to ensure that people's rights were upheld and decisions were made in the best interests of people who lacked the mental capacity to make specific decisions themselves. Regulation 11 (3).

The enforcement action we took:

On 12 February 2021, we issued the provider with a notice of proposal to cancel their registration with CQC. The notice of proposal was adopted, and a notice of decision was issued on 16 April 2021 to cancel the provider's registration. The provider had an opportunity to appeal to the first-tier tribunal court which they did, but subsequently withdrew their appeal in November 2021. Therefore, we have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An effective system to receive and act on complaints was not in place. Regulation 16 (1)(2).

The enforcement action we took:

On 12 February 2021, we issued the provider with a notice of proposal to cancel their registration with CQC. The notice of proposal was adopted, and a notice of decision was issued on 16 April 2021 to cancel the provider's registration. The provider had an opportunity to appeal to the first-tier tribunal court which they did, but subsequently withdrew their appeal in November 2021. Therefore, we have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not in place to ensure compliance with the regulations. The governance systems in place were not robust enough to identify shortfalls in quality and safety.The provider failed to ensure the service was assessed and monitored to improve quality and safety. Regulation 17 (1)(2)(a)(b)(e)(f).

The enforcement action we took:

On 12 February 2021, we issued the provider with a notice of proposal to cancel their registration with CQC. The notice of proposal was adopted, and a notice of decision was issued on 16 April 2021 to cancel the provider's registration. The provider had an opportunity to appeal to the first-tier tribunal court which they did, but subsequently withdrew their appeal in November 2021. Therefore, we have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing An effective system was not in place to ensure staff were suitably trained. Regulation 18 (2)(a).

The enforcement action we took:

On 12 February 2021, we issued the provider with a notice of proposal to cancel their registration with CQC. The notice of proposal was adopted, and a notice of decision was issued on 16 April 2021 to cancel the provider's registration. The provider had an opportunity to appeal to the first-tier tribunal court which they did, but subsequently withdrew their appeal in November 2021. Therefore, we have cancelled the provider's registration.