Endurance Care Ltd

Coppice Lodge

Inspection report

66-68 Walter Nash Road East
Kidderminster
Worcestershire
DY11 7BY

Date of inspection visit:
16 January 2019

Date of publication:
05 March 2019

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

Summary of findings

Overall summary

The provider registered with the Care Quality Commission (CQC) in February 2018. This was the first inspection under this provider and therefore their first rating.

Coppice Lodge 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.

Coppice Lodge accommodates eight people with a learning disability in one adapted building which is over two floors. There were seven people living in the home when we completed our inspection visit.

The care service has been 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. Registering the Right Support CQC policy

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager, while still active on the register, left the company in April 2018. The manager who we met on inspection had worked in the home for three weeks prior to our arrival.

At this inspection we found the service was inadequate overall, and in the key questions safe, effective and well-led. The inspection identified five breaches of regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms 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.

Where risks to people's health were identified people had not been adequately assessed or reviewed to understand if the support in place was adequate. Staff were not provided with clear and accurate guidance as care records were not readily available, incomplete and historic to ensure people risks of harm were being managed and mitigated in the right way. This exposed people to potential harm of unsafe care and treatment. There were sufficient staff to keep people safe. People's as required medication was not always managed in a safe way; as staff did not have clear guidance on how and when this should be given.

People had not had proper assessments of their care. People, their relatives and professionals had not been involved in the planning of the care to ensure this was consistently being delivered in the right way. The provider could not be assured that they had not followed the principles of The Mental Capacity Act 2005 (MCA) and could not demonstrate that care and support was being offered in people's best interests. Staff did not recognise when they were restricting people. Where applications had been made to Deprivation of Liberty Safeguards (DoLS) these were not available to the manager to understand who had them and how care was to be provided in a legalised way.

Staff were not supported by the provider to keep their skills and knowledge up to date. The provider did not have checks in place to demonstrate staff were competent in their roles.

The provider could not demonstrate that people always had access to routine appointments such as dentist and optician, and their annual health care checks were out of date. We found that people had access to healthcare professionals when they became unwell or had an accident. Where healthcare professionals did visit, communication about changes in care was not consistently shared with staff.

The provider had not promoted people's dignity and privacy. Aspects of the environment, and an institutionalised culture within the service compromised people's dignity.

Most staff knew people well and understood their likes and dislikes and how to meet their interests. People did were supported to maintain their interests and hobbies, however plans for the day and developing future plans had not taken place to give people structure. The provider did not meet the requirements of The Accessible Information Standard. This aims to make sure that people who have a disability or sensory loss get information that they can access and understand, and any communication support that they need.

People and staff felt the manager was supportive. The provider did not have effective systems in place to ensure the service was delivering good quality care.

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.

The provider had failed to identify and address serious risks to people's health and well-being.

Medicines were not being managed safely and people could not be assured that they would receive their prescribed medicines.

People were not always protected from environmental and infection risks, as measures in place to identify and reduce these risks were not always sufficient.

Is the service effective?

Inadequate

The service was not effective.

The provider did not ensure staff were given the training to develop their skills and knowledge and put this into practice.

People were not always supported to access relevant health and social care professionals to ensure they received the care and treatment that they needed.

The principles of the Mental Capacity Act (MCA) 2005 had not been applied appropriately. Authorisations to restrict people's liberty where not known by staff to ensure these were followed.

Mealtime experiences for people was poor and unorganised.

Is the service caring?

Requires Improvement

The service was not caring.

People's dignity was not maintained and their privacy not always respected.

Staff did not always engage with people in a meaningful way and promote their independence.

Is the service responsive?

Requires Improvement

Peoples care and support needs were not fully met in-line with their preferences.

People were not involved in their care, and there were no clear plans or activities scheduled for people to look forward to.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have systems effective systems in place to monitor and review the governance of the service.

There were no reliable and effective systems to assure people's views were sought or opportunities given to influence the service they received.

The lack of oversight of the service had resulted in areas of improvement not being identified.

Poor and ineffective record keeping and communication impacted on the quality of the service provided.

Coppice Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 January 2019 and was unannounced. The inspection team consisted of one inspector.

Prior to our inspection we received concerns around aspects of people's safety and the staffing levels. We considered this information as part of our inspection.

Before our inspection we reviewed all the information we held about the service. This included notifications which contained details of events and incidents which the provider is required to notify us about by law. We also looked at information provided through the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The commissioners for health and social care, responsible for funding people who used the service had shared information with us concerning the service. This information was used to inform our inspection planning.

We spoke with two people using the service and spent time with people in the communal areas of the home. We spoke with four support workers, the business administrator, the service manager, the home manager and following the visit the area operations manager.

We looked at the recruitment records for three staff and staff training information. We looked one care record that was in the early stages of completion and one care record that had not been written under the previous provider. We also looked at aspects of people's medicine records. We looked at the previous providers environmental risk assessments as this was available on the day of inspection. Following the inspection, we reviewed documentation relating environmental risk assessments ad fire safety assessments,

such as personal evacuation records and fire safety audits.

Inadequate

Is the service safe?

Our findings

We found that the provider had identified risks to people and not taken appropriate action to keep them safe. For example, one person with mobility issues needed a specific piece of equipment in the event of a fire. The provide had failed to acquire this equipment for over 12 months and the person had been left at risk of potential harm in the event of an emergency evacuation. Following our inspection, the provider confirmed the equipment had now been ordered and all people's personal evacuation assessments would be reviewed as priority.

People were at risk of potential harm as the provider did not have complete up-to-date knowledge of potential risks to people and how these were to be mitigated to keep them safe. On the day of our inspection visit people's care records were being stored in the staff's sleep in room, due to the flooring being replaced in the office a few days prior. However, the storage of care records was disorganised and not readily available to staff. New care records were being created for people, but we were advised that this was incomplete. We looked at a care record which had not been reviewed by the manager and written by the previous provider, however this did not give a clear picture of the person, what their care and support needs were and how any risks were to be managed by staff. Staff gave varying accounts of how they managed known risks to people, such as choking. Staff told us they had seen inconsistencies with types of food offered to people who were at risk of choking, and felt that communication needed to improve safety. Following the inspection, we asked the provider to ensure up-to date risk assessments were in place and staff informed, to ensure people were receiving the right specialised diet.

The environment and staff practice put people at risk of potential injury or exposed to infection. The provider was working towards improving the environment and had painted communal areas, upgraded the kitchen and replaced the flooring throughout the home, except for the bathrooms, which we were told were to also be completed. However, we saw people's bedrooms were basic in their furnishings but also stored other items such as a large electrical fan that was covered in thick dust, a broken armchair in another person's room, and broken window cover in a further person's bedroom. Some of the rooms where cold and the radiator covers damaged. In one bedroom the bed was against the radiator without a radiator cover in place, along with an exposed pipe that was hot to the touch. We raised this with the provider who made this radiator safe.

While the communal areas were clean, the upstairs toilet had a fluid on the floor with a foul-smelling odour which was there in the morning and when we looked again in the afternoon. People also did not have access to hand soap or paper towels in the upstairs toilet. People did not have laundry baskets to put their laundry in, and we saw unwashed clothes were on the floor in the laundry room. The manager confirmed that since their arrival they had put in place specialist bags for soiled laundry, and these were being used by staff. One staff member we spoke with told us they had not completed their food hygiene or infection control training, but cooked and cleaned, while two further staff reported that they had this training but by the previous provider. We also saw that some staff who supported people had long painted nails and wore jewellery on their fingers and arms.

People did not always receive their medicines safely. There was a staff member on duty who was trained to deliver medicines for people on duty. The manager told us that they had recently moved to another pharmacy supplier to deliver the medicines. However, we found some practices were not robust to ensure people were receiving the right medicine in a safe way. For example, where people were prescribed medicine on an 'as required' basis. There were no protocols or guidelines to advise staff when the medication should be given. The medication record for one person showed that an anti-psychotic drug was given on 12 January 2019. There was no recorded reason why this medication was given and what other techniques had taken place prior to this. The staff member advised that the person had been shouting for 45 minutes, but with no clear guidelines for staff to follow the provider could not be assured that staff were administering the 'as required' medication under the right conditions.

We were told that one person had epilepsy and suffered with seizures. We found that they were prescribed rescue medication in the event of a seizure. The manager told us that their seizures 'were bad' and that 999 should be called as they had identified that all staff's training for administration of the rescue medication had lapsed. When we spoke with staff, staff gave varying accounts on what they would do in the event of a seizure. One staff member said they would call an ambulance after five minutes, while a further staff member felt their training was still valid and would administer the medicine. Without clear care records to understand the person's seizures, patterns and recovery time the provider could not be assured that staff were consistent in their approach to keeping the person safe, and that staff would be able to respond effectively.

This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

We spent time in the communal areas of the home and saw people were comfortable when they were with staff. We spoke with staff about how they kept people safe from harm of abuse. All staff we spoke with about this knew how to identify abuse and how to report any concerns, including to outside agencies such as the local authority and the Care Quality Commission. Staff told us they would and have previously raised concerns, including through the whistleblowing process. Whistleblowing is where staff can highlight poor practice without fear of recriminations.

Prior to our inspection we had received concerns regarding aspects of the care and treatment of people who lived in the home. We spoke with the provider who told us, they had identified a safeguarding concern and reported this to the correct authorities, however through speaking with the local authority and reviewing our own records we found that these safeguarding's had not been raised. We made the provider aware of our findings, and since this they have ensured the safeguarding's have been made to the local authority and the CQC have received the notifications. However, the actions were taken as a result of our inspection findings and not through the providers own course of action.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

The provider had suitable staffing levels in place to ensure where people required one to one support, or two staff to support them in the community this was in place. However, staff told us that they were also allocated other roles while providing one to one support, such as laundry, cooking or cleaning. Staff felt these tasks took them away from offering the fullest support to people. On the day of our visit, we heard an example, where one person became anxious while in the communal area, however the allocated staff member was completing laundry tasks. Staff were unclear why people required one to one support while in communal areas of the home. The manager advised they were requesting social worker reviews so that clear

understanding of the support could be sort as the care records did not indicate the purpose of the necessary support. We spoke with the manager who told us they were holding a team meeting and would discuss with staff their concerns. They told us they were working with staff to increase people's independence with day to day tasks, so that where it was safe and appropriate, people would be involved in daily tasks such as meal preparation and doing their laundry. Staff told us that should any staff take unplanned leave, such as sickness, they had used agency staff who had worked at the service before and knew people well.

Inadequate

Is the service effective?

Our findings

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.

Staff were able to demonstrate to us their knowledge of the Mental Capacity Act [MCA], however this knowledge was not always applied into their everyday practices. We found there was an institutionalised culture within the home, which was risk adverse and in doing so, restricted and limited people's choice, without a clear reason why the decisions were being made. For example, a blanket rule within the home was for every person's wardrobes in their bedrooms to be locked, should people want something from their wardrobe they needed to ask a staff member to unlock it for them. We asked staff why people's wardrobes were locked, one staff member said, "I don't know, they've always been locked". While another staff member told us, it was to stop a person from wearing too many items of clothing." We discussed this with the manager who told us they had recognised other restrictions, such as bedrooms being locked and a locked kitchen and were working with staff to provide people with more choice and less restrictive practices.

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 manager told us that they were aware that three people had been authorised a DoLS, however the authorisation could not be found, to ensure these DoL and any potential conditions within the authorisation was being met. Two staff we spoke with thought that no-one living in the home had a DoLS in place. We spoke with the local authority following our inspection, who confirmed that people had a DoLS in place. Therefore, the provider could not be assured they were acting and responding in-line with the authorisation to restrict people's liberty.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

The provider had failed to demonstrate they were supporting people in-line with their care needs. We found that up-to-date care assessments of all people's needs had not taken place since the provider started providing a service to people in February 2018 and the care records were either incomplete, or not readily available. We asked the manager if families had been involved when they began creating new care records for a person, however the manager said they had not contacted families. The manager also advised that the

provider had requested social worker reviews for all people living in the home, so that people's plans of care could be discussed. However, until these assessments were completed and shared with staff, people received inconsistent care. For example, four staff we spoke with gave varying views in how they would support a person to wash safely, with some staff saying they would use a standard bath, while another staff member saying they would bed bath as the bath was unsuitable. Without a comprehensive assessment of people's care and support needs the provider could not be assured that they were delivering care and support that met people's needs.

The provider had failed to ensure people received routine appointments to maintain their health. The manager told us that people had not received an up to date annual health check with their doctor and due to the management of the care records it could also not be determined whether people had received social worker reviews, so that a clear understanding of what service user's current health and social needs where to ensure they were meeting these. Staff were also unclear about routine health check-ups such as dentist and optician. One staff member said, "I think I have seen the chiropodist coming in". However, without clear and organised communication, and with lack of care records available to confirm, the provider could not be assured that people were receiving these routine appointments. The manager did confirm that since their arrival they had booked appointments with people's doctors so that annual health checks could be carried out.

This is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred Care.

The provider had not supported staff to stay up to date with their training so they could deliver care and support to people which was in line with best practice. Some staff told us they had not received any mandatory training, apart from Management of Actual or Potential Aggression, (MAPA), while another staff told us they had completed training with their previous employment. The manager told us that training was online based, and staff had not been able to connect to this due to technical difficulties. They told us that since their arrival, they had booked training such as safe administration of rescue medication, and that the provider was coming to the home to ensure all staff could access the training offered online.

Staff told us they all worked as a team and the manager had introduced a handover of information at each shift. Staff told us that this was working well, as it gave them clear direction and guidance on which staff member was supporting which person.

We spent time in the communal area during lunch time to understand people's experiences. We found this to be an unorganised and poor experience for people. One person was eating their lunch as they were being assessed by the visiting speech and language therapist, however there were three other people who were also sat in the dining room but did not have any food available to them, while a staff member ate their lunch. Sometime later, we saw one of these people being supported to eat a sandwich, however the person was sat on a metal chair with no table, with the staff member stood in front of them giving them small pieces of sandwich, however did not engage with the person, but later on that day, we saw the person was eating a piece of fruit independently.

Staff we spoke with told us that no person was at risk of malnutrition or obesity, however it could not be determined if people's weights were monitored and reviewed to ensure people were a healthy weight, as care records were unavailable. Staff told us that six people were on fluid charts to monitor their fluid intake, however staff were unable to explain why they were monitored and how much each individual person was required to drink to keep them healthy.

Coppice Lodge has been adapted into a care home for those people who require residential care. At the time of our visit the provider was renewing the flooring throughout the home. However, we found the premises did not always support people's independence. We found that the provider had not carried out and followed through risk assessments where the environment had impacted on a person using the service. For example, the showers and baths within the home were just regular bathroom facilities and did not safely support a person with poor mobility to access these, which placed people at potential risk of injury.

Requires Improvement

Is the service caring?

Our findings

The provider had not ensured that the environment and the staff who supported people, were working in line with their vision and values. We asked people if they enjoyed living in the home and liked the staff who supported them. One person gave us the thumbs up, while a further person confirmed they did. Staff spoke fondly of the people they supported, and felt they were part of a family and staff felt proud of their support they offered people. However, staff did express their frustrations to us with the environment. Staff felt it did not promote people's dignity. Staff showed us people's bedrooms, where we saw one person's window which overlooked the main road, had a wooden sliding shutter, however this was broken and could not be fully shut. This did not promote the person's privacy. While another people slept on a mattress that had a thick plastic mattress protector which was similar to plastic packaging. This did not promote the person's dignity or comfort. Other rooms had items such as broken arm chairs, where we saw the back of the armchair was on the floor, electrical equipment, boxes and clutter piled into corners.

Some staff told us that when they had raised concerns about poor practice within the home, previous management had not taken action to address this. For example, one staff member told us how a culture had developed where newer staff or agency staff did not engage with people and involve people with tasks around the home. However, they felt that things had started to improve since the new manager arrived and told us they now felt listened to and concerns were being addressed promptly.

During the inspection we did observe some staff's behaviours lacked respect towards people. For example, in the afternoon staff were sat in the lounge with people, however there was very little engagement and no activities taking place, some staff sat with their coats on, but nobody went outside. When a person needed support after sneezing, a staff member made sounds of disgust, rolling their eyes and expressed their disappointment with the person. Another example we heard as we walked into a communal room was a staff member screaming 'ow', and they explained a person pinched their leg, however this scream caused other people in the room some alarm. We spoke with the manager about what we had seen and heard. The manager was aware that some staff needed further development with supporting people in a dignified and respectful way, we saw the manager led by example and spoke with people in a respectful way.

People were not encouraged to maintain their independence and make their own day to day decisions. People were not part of the running of the home to enable them to feel valued. Staff could not show us how they supported people to increase their independence for example, through developing skills to equip them with a more independent way of living. There was a lack of understanding from staff as to how support people with their life choices, cultural and religious beliefs. There were no communication aids, and no clear understanding how staff communicated with people individually to allow them to express themselves.

All of the above information demonstrates there was a breach in regulation which was Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Dignity and Respect.

Requires Improvement

Is the service responsive?

Our findings

Most staff knew people well and were able to tell us people's individual routines, likes and dislikes and their interests. One member of staff said, "People can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right." Staff told us that one person had access to their own car, which meant they were able to travel further afield. Staff told us they wanted to work with the manager to help another person have access to their own car to enable them to get out and about more often as public transport was not always suitable for the person. Staff spoke of the activities people enjoyed such as swimming, going out for food, and local walks and we could see that people responded positively when staff confirmed with people the activities that they enjoyed. During our inspection visit we met one person who had returned from a walk with staff. However, there were no other planned activities for the day with other people, and we saw their day was spent sitting in the communal areas with staff. One staff member attempted to build a jigsaw with a person, but the person showed no interest in this activity.

Due to the lack of care records that were complete and up to date, the provider could not be assured that people were receiving personalised care that met their needs in a responsive way. The manager was identifying action that was required through spending time with people and conversations with staff. This is what prompted them to book the annual health checks with people's doctors. However, the manager felt there were other aspects of people's health and wellbeing that needed to be addressed, but could not fully identify and action these until they had a baseline of the annual health check to start with.

The provider did not meet the requirements of The Accessible Information Standard. This aims to make sure that people who have a disability or sensory loss get information that they can access and understand, and any communication support that they need. Some staff told us they knew people well, and recognised what their individual sounds or gestures meant. However, we could not see that any other types of communication methods were used, such as showing objects of reference, pictures and a communication board, so they could be sure they were providing information and offering choices to people.

There was no person living at the home who was currently receiving end of life care. They told us that through knowing people well, they understood their preferences to be able to reflect this is their end of life care.

People did not show us signs of complaints or concerns they may have. Some staff we spoke with told us they had expressed concerns about the service provision in the past, but felt these were being addressed. The CQC had received a concern from a family member prior to our inspection and we shared this with the provider so it could be addressed. The manager had been in the home for three weeks and was aware of the family members complaints prior to their arrival. The manager advised they had not been made aware of any other complaints, or received any formal complaints since they started working at the home. We were unable to determine if there had been previous complaints regarding the service, as the storage of records made this difficult.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the registered manager was not in post. While they remained as active on the register, the provider confirmed they left in April 2018. Since the registered manager left, the home had been managed by a further two managers. The manager who we met on our inspection visit had been working in the home for three weeks.

The provider could not demonstrate they had spoken with people, their relatives and advocates to understand if the service provision was meeting people's needs. Where there had been changes made to the environment, the provider could not evidence this was in line with people's involvement and their wishes. Staff told us that people had been through a lot of change and disruption over the recent months, with changes to their environment, staffing and management, however, it could not be demonstrated how the provider was supporting people with these big changes.

We asked the manager if they were working on any action plans given to them by the provider. The manager advised they were not aware of any action plans and said that through speaking with staff and reviewing paperwork they were identifying shortfalls and addressing these as they arose. Following our inspection visit we spoke with the Area Operations Manager who confirmed that the provider was reliant on home managers to 'self-audit the service'. The manager confirmed that they do not have access to any budget or money to support the service at local level to help drive improvement. However, the manager felt that as they were raising concerns with the provider and they were responsive to their requests and support was being offered. However, the reliance of self-management and self-audit in a home where there has been disruption and inconsistencies in management is inadequate to ensure the service is running safely and effectively and in doing so has exposed people to potential risk or harm and/or injury.

The providers systems for reporting, monitoring and progressing incidents such as safeguarding's are ineffective. The manager told us that three people had been identified as being at risk of abuse in November 2018 and the authorities had been notified. However, the inspector had to contact the Area Operations Manager following the inspection to advise that following a telephone call to safeguarding that safeguarding referrals had not been made to the local authority nor had CQC been notified of the allegations of abuse. The provider had failed to ensure that people were protected from the risk of harm and when identified had failed to take appropriate actions to keep them safe due to their ineffective systems.

The providers systems had not identified that records held were not accurate, contemporaneous or stored appropriately. Records for people's current care and support needs, were not readily available, and records that we saw were historic, with no clear picture of their current care, support, health, capacity and understanding.

The provider had failed to ensure that the staff who worked for them were equipped with the right skills and competency to carry out their role and ensure people received safe care and treatment in line with best practice. The manager advised that the provider was aware that staff required training in order to meet their mandatory training requirements, such as medicines, first aid and food hygiene, however the provider had

not taken action to ensues staff could access the online training. There was no clear system to report or review serious incidents including choking, falls, injury to people or staff, medication errors, abuse including near misses. This meant for example, where a person was having seizure incidents there was no review or assessment that took place to ensure the person continued to receive the right care and treatment. The lack of monitoring systems meant that the provider could not identify potential shortfalls in staff's knowledge and understanding, to develop this through refresher training and additional competency checks. With no systems to highlight and address incidents the provider was putting people at risk of potential harm that could have been avoided.

The provider could not be assured that up until the inspection people were living in a safe environment. During our inspection we found aspects of the service which could be a potential risk, such as fire safety and environmental risks. We saw there was an exposed radiator pipe in one person's bedroom which was hot to the touch and the bed was against radiator which had no radiator cover. The environmental risk assessments viewed on inspection were written in 2013 by the previous provider, while reviewed annually they stated, 'no change'. While action has been taken since the inspection to make this radiator safe, we asked the provider if they had completed an up to date environmental risk assessment that may have not been available on the day of the inspection. However, following the inspection the provider sent to us an environmental risk assessment that was completed after the inspection took place. The provider also sent us the fire safety audit, which was completed in December 2018 by an external contractor, shortfalls had been identified that required action within three months, however the manager was not aware of these and there were no clear plans these shortfalls were going to be addressed.

The provider did not have systems in place to ensure the environment was clean and hygienic and as a result we saw people were at risk of cross infection. The examples we saw of poor hygiene of the home with unkempt bedrooms, and bathroom with malodours, that had not been addressed by the provider. The provider had not always led by example in developing the home to be a friendly, homely safe place for people to live.

All of the above information demonstrates there was a breach in regulation which was Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

We spoke with the provider following our inspection to discuss our concerns so that action could be taken quickly to address these. Throughout these conversations the provider has listened and responded to our requests. The provider has demonstrated openness and transparency through this process and has acknowledged that the systems they were reliant on where not effective, and new monitoring systems are being looked at, for example, developing a compliance team to monitor and review the service. They advised they were working with the local authority and other health and social care professionals to ensure people and staff are supported going forward. However, it needs to be recognised that these systems take time to develop, embed and establish to ensure they are effective in driving and sustaining improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care, as there were no clear assessments of people's needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and respect were compromised due to environmental factors and cultural behaviours within the staff group.

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 People were not protected from abuse as the providers systems for reporting, progressing and monitoring were ineffective.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have systems in place to assess, mitigate and review risk. The provider had not ensured staff were trained and competent in their role to deliver care safely.

The enforcement action we took:

Urgent Notice of Decision to impose conditions on registration and restriction of admissions into the home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have established or effective governance systems in place to ensure they were providing a good service provision and take action where shortfalls were identified.

The enforcement action we took:

Urgent Notice of Decision to impose conditions on registration and restriction on admissions into the home.