Wellington Healthcare (Arden) Ltd

Rowan Garth Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rowan Garth is a residential care home providing nursing and personal care to 120 people aged 65 and over at the time of the inspection. The service is registered to support up to 150 people over five single storey units. Each unit specialised in different types of support. These included residential or nursing care for people with a variety of health and care needs, including those living with advanced dementia.

People's experience of using this service and what we found
People were at risk of harm because risks were not assessed, recorded or manged effectively. Safeguarding procedures aimed to keep people safe were not consistently implemented and incidents had not always been reported or investigated.

Medicines were not administered safely. Not all staff with responsibility for administering medicines had received training or had their competency assessed. Training for staff in other areas such as the Mental Capacity Act, safeguarding and safe moving and handling was also poorly completed.

There were shortfalls in relation to the management of infection and prevention control. Used linen storage and clinical waste was not safely managed and this increased the risk of cross infection throughout the service. We raised the concerns with the registered manager after the first day of the inspection and action was taken to reduce the risk of infection.

There was a lack of working together with external agencies to deliver effective care and treatment and support people's access to healthcare services. This meant their needs were not being met and had a negative impact on people's well-being.

People were at risk of receiving inadequate care that did not meet their needs because assessments and care plans were poorly completed and not person-centred. Records were either incomplete, inaccurate or lacked detail to provide staff with guidance on how to support people in line with their needs and preferences.

People's rights were not always protected by the actions of the service and people were not always treated with dignity and respect. 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.

There was lack of evidence to show that people were involved in decisions about their care, support and treatment. Some relatives told us there was lack of communication and involvement in care planning.

The management and leadership of the service was inadequate. Systems to monitor, assess and improve the safety and quality of service being provided were ineffective.

Relatives told us they felt communication with the staff and management team could be improved, but they felt staff were doing their best. Relatives were complimentary about arrangements made for visiting during COVID-19 and felt this had been done safely.

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 7th March 2020).

Why we inspected
We undertook this inspection to follow up on concerns which we had received about the service. The inspection was prompted in part due to concerns received about standards of care, staffing and records. A decision was made for us to inspect and examine those risks under the key questions of Safe and Well-led.

We inspected and found there were further concerns, so we widened the scope of the inspection and looked at all five key questions.

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 COVID-19 and other infection outbreaks effectively.

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

The registered provider has been responsive to concerns noted during the inspection and has started to take action to make improvements and promote safety within the home. We were sent an action plan shortly after the inspection.

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 have identified breaches in relation to person-centred care, dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, staffing and good governance.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not 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.

Rowan Garth 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 Care Act 2014.

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 carried out by four inspectors, a specialist pharmacist inspector, a medicines inspector and two Experts 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
Rowan Garth 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 16 relatives about their experience of the care provided. We spoke with 16 members of staff including the registered manager, clinical support manager, provider, nurses, senior care workers and care workers.

We reviewed a range of records. This included 17 people's care records, and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at rotas and training records.

Due to the number of serious concerns found during the inspection we referred concerns to the local authority.

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.

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

At the last inspection we recommended the service reviewed their fire safety checks. At this inspection we noted improvements in health and safety checks. However, we found significant concerns with other aspects of risk management and emergency evacuation planning. The provider was now in breach of regulation.

- People were exposed to serious risk of harm due to a lack of person-centred risk assessment. Risk assessments were either not completed, not accurate or reflective of people's current needs, or detailed enough to guide staff on safely supporting people.
- Where people were supported with bedrails, there were no risk assessments in place to ensure risks to people had been assessed and managed. Bed rails checks were not always completed to make sure they were safe. There had been two previous bed rail entrapments involving people at the service and the lack of effective management of bed rails showed lessons had not been learnt to prevent repeat incidents.
- People with specific health conditions such as diabetes, had no care plans to guide staff on how to safely support them. Records did not reflect the specialised diets they needed to support management of their diabetes and food charts showed people were not always supported with diabetic diets.
- Risks associated with wounds and pressure area care were not managed appropriately. Care plans did not contain guidance about the correct mattress setting. Staff did not always know what the correct setting was and guidance on how people's wounds should be cared for was missing.
- Personal emergency evacuation plans were not always completed accurately or fully. Not all staff knew where these records were kept. This placed people at risk of harm in the event of an emergency situation.
- There was a process in place to record accidents and incidents, but this wasn't always followed. There were incidents that had not been recorded or investigated.
- Accident and incident analysis were not robust enough to prevent further incidents.

There was a failure to robustly assess risks relating to the health, safety and welfare of people. Lessons had not been learnt to prevent repeat incidents. This placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to the risk associated with bedrails, emergency evacuation and reviewed people's care records to ensure they were accurate and up to date.

Using medicines safely

● Medicines were not always administered safely and in line with best practice and any prescriber instructions. This placed people at unnecessary and avoidable risk of harm.

● Covert medicines were not being given in accordance with the Mental Capacity Act 2005. For example, for one person living at the home staff did not have clear guidance on what medicines were to be administered covertly. There was also no advice from a pharmacist about how the covert medicines could be given safely.

● During our observations of medicines administration we saw prescribed medicine being left in communal areas for people. There were no staff present to ensure the medicine was not taken by others in error.

● There were no person-centred care plans for people's specific medicines. For example, three people were prescribed insulin but there was no information about blood glucose levels monitoring, including the frequency and acceptable range and what to do if blood glucose levels were outside of the acceptable range. One record showed a person's blood glucose levels were significantly lower on one day than any other, but no action had been taken.

Medicines were not administered or managed safely. This was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection and put plans in place to ensure all staff were trained to administer medicines safely.

Preventing and controlling infection

● There were shortfalls in relation to the management of infection and prevention control (IPC). Used linen storage and clinical waste was not safely managed and this increased the risk of cross infection throughout the service. On the second day of the inspection we saw IPC processes had improved.

● Bathroom areas were cluttered with excessive storage of moving and handling equipment. We found incontinence products and personal protective clothing stored in bathrooms on some units which increased the risk of infectious disease being transmitted.

● One sling to support the safe moving of people was soiled and in use. The same sling was used for multiple people.

Systems and processes were not effective to prevent the control and spread of infection. This was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff followed appropriate IPC guidance in relation to COVID-19. Testing was in place and personal protective equipment was worn in line with guidance.

Systems and processes to safeguard people from the risk of abuse

● There were ineffective processes in place to protect people from abuse or investigate and act on allegations or evidence of abuse. This meant that people were not effectively safeguarded from abuse.

● Where people were found with unexplained bruising this had not been documented or escalated appropriately. These incidents were not investigated to ensure people had not suffered abuse.

● Restrictive practices were being used without due regard to the person's needs, safety, or appropriateness. Restrictive practices were not reviewed to ensure they were still needed and the most appropriate intervention.

Processes were not effective to protect people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The provider took action after the inspection to review restrictive practices.

Staffing and recruitment

At the last inspection we recommended the service review their recruitment checks and staffing procedures for robustness and consistency. At this inspection we found some improvements had been made. However, further improvements were needed to ensure staffing levels were consistent with people's dependency needs.

● Staff recruitment was undertaken in a safe way however, we noted inconsistencies in reference request processes across the staff records we looked at. This has not been identified through the providers governance checks.
● We received mixed feedback about whether there were enough staff at the service. Staff on some units told us they were short staffed and needed more support. One staff member said, "Sometimes we don't have enough staff; they [management] are constantly taking us [staff] from one unit to work on another unit." Relatives told us they hadn't been able to visit the home much due to COVID-19 but overall felt there were enough staff.
● We looked at staff rotas and observed staffing levels during our inspection. We saw that there were enough staff to meet people's basic needs. However, staffing levels were not calculated effectively as information regarding people's dependency levels was often out of date and inaccurate. We have reported on this in the well-led section of this report.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment 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.

- The service was not working within the principles of the MCA. People were at risk of having their liberty unlawfully restricted and inappropriate decisions could be made on a person's behalf if they lacked capacity to make the decision for themselves.
- Consent to care and treatment was not always gained from people. Where people had the capacity to consent, consent had not always been recorded. Where there were concerns over a person's ability to consent, legal processes were not followed to ensure decisions were made in their best interest.
- Restrictive practices, such as the use of bed rails, were being used without appropriate legal authority. Processes had not been followed to ensure these practices were the least restrictive option and, in the person's best interest.
- Policies and procedures regarding consent were not being followed. Not all staff were aware of these processes, and not all staff had received training in the MCA. Some staff told us they did not understand the MCA.

There was a failure to act within the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff were not always sufficiently trained, supervised and appraised in their roles. This meant that people were at risk of being supported by staff who did not have the necessary skills and competence to do so safely.

● Staff training records showed not all staff had received training needed to do their roles competently. Training such as safeguarding, fire safety, the Mental Capacity Act, medicines management, diabetes and moving and handling had not always been completed.

● The supervision and appraisal records also showed staff had not received appropriate support in their roles. Some staff told us they had not received any supervision. The registered manager reported concerns with some staff competence, but no further support had been put in place for these staff.

Staff were not appropriately trained and supervised in their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was an induction process that was aligned to the care certificate. However, it wasn't clear from records if this had always been completed in full by new staff.

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

● People's physical, mental health and social needs were not consistently assessed in line with legislation, standards and evidence-based guidance, and other expert professional bodies, to achieve effective outcomes. Wound care and people's deteriorating physical and mental wellbeing were not adequately assessed or recorded.

● Assessments of people's care needs had not always been completed in detail. Most care plans lacked detail around specific needs. This meant people were at risk of not having their needs safely and effectively met.

People's needs were not assessed effectively and did not reflect their needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were at risk of not having their nutritional needs met. Records showed that when people required their food and fluid intake to be monitored, this was not always recorded effectively.

● Where people required specialist diets this was not always recorded in their care plans. Not all staff knew when people needed to be supported with a specialist diet.

● Relatives felt their loved one's nutritional needs were met, and most told us people had put weight on since admission to the home.

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

● People were referred to outside multi-agency professionals for routine assessments including; dieticians, podiatry and physiotherapy. We found professional guidance had been followed in most cases. However, information used to inform these assessments was not always up to date or accurate.

● People's health needs were not regularly reviewed and when people's health deteriorated this was not always identified in a timely manner. There had been a number of safeguarding's which highlighted failure to refer people for acute healthcare assessment when their health had deteriorated.

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

● One unit had been recently refurbished and was designed and decorated to meet people's needs. Other

units were older and not always suitable for meeting people's needs. The provider told us plans were in place for a full refurbishment of all the units.

Inadequate

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 inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- We saw people laid on thread bare linen and one person who lived with dementia had been covered with a curtain because staff told us they did not always have access to clean linen.
- We observed one person's room where a soiled duvet had been left on the chair in the corner of their room for the majority of the morning.
- People were not always supported to maintain their independence. Restrictive equipment was being used, for example bedrails and specialist chairs, without rationale or consideration for other equipment which would promote safety and independence.
- People who were on long term bed rest did not have support plans to show rationale, consideration for alternative equipment or how staff would ensure they had positive wellbeing outcomes.
- People's privacy needs and expectations were not documented. There were no records of discussions with people (or relevant others) regarding their preferences for care, such as gender of carer or any personal care preferences. We found bathrooms on some units had not been used during the morning. Staff told us there was not always time to support people with bathing at this time as they were busy during the morning, and instead tried to support people later in the afternoon or evening.
- People's personal possessions such as clothes and memorabilia were not always treated with respect. One relative told us, "We provided a montage of photos of loved ones and family as a reminder to [person]. We found this montage of photos on the floor, half hidden behind the chest of drawers. It had not been stood up or placed on the wall and [person] could not even see this when in bed."

People were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Interactions we saw with staff and people were carried out in a caring and compassionate way. However, these interactions were not always meaningful, and support was often task orientated.

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

- People were not always supported to be involved in decisions about their care. Care records showed a lack of assessment and involvement from people.
- Relatives with the appropriate legal authority were not always included in discussions about people's care. One relative said, "There have been no meetings, questionnaires or the video calls that were meant to be being arranged and I've had no involvement in the care plan at all".

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not consistently supported in a person-centred way. Care records had not always been completed to show person-centred care planning. Records were not updated, reviewed or evaluated effectively to ensure people's needs were met.
- Some people's care plans contained contradictory information, had not been updated and lacked detail. For, example one person's care plan stated that they were compliant taking their medication. However, information elsewhere indicated they were to be given their medicines covertly.
- People were not always receiving support as documented within their care plans. For example, two people's care plans stated they were to have their food and fluid monitored due to nutritional risks, but no monitoring charts were in place.
- People and their relatives had not always been provided with information to support them with making decisions about care and support. Some relatives told us communication was poor and there was no involvement in care planning. One relative said, "I've never been involved in [person's] care plan. We have sometimes found it difficult to get in touch with the unit, for example, it took 2 hours on the phone the other day to find out how [person] was after health issues the week before. We found out that [person] had started treatment."
- Throughout our observations we found staff were task focused. We did not observe many meaningful activities and staff told us they rarely had time to engage with people unless they were undertaking tasks to provide personal care. Staff told us they did not always have the time to "sit and chat" with people as they were "always on the go." At times staff were very busy, and we observed people sat in the lounges with very little interaction.
- People were not always supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them.

People were not supported with person-centred care, and care did not always meet their needs. This was a breach of Regulation 9 (Person-centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs; Supporting people to develop and maintain relationships to avoid social isolation

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.

● People's communication needs were not always identified in their care plans.

● There was lack of information in a format that people living with dementia could understand.

● There were limited activities in the home. On one unit we saw an activities coordinator was available, however limited activities were seen taking place. The activities coordinator was supporting with other tasks throughout day one of the inspection, such as supporting with serving drinks and food.

● Since visiting restrictions imposed during the COVID-19 pandemic had been eased, relatives said they had been able to visit their loved ones safely.

Improving care quality in response to complaints or concerns

● A complaints system was in place. Although some relatives had not formally complained to the management team, they said when they raised concerns there was a lack of response from the managers.

● When formal complaints had been raised, they had not always been responded to in a timely manner. Relatives were not always updated with an outcome of their complaint.

End of life care and support

● People's end of life needs and wishes were not always discussed in a timely or person-centred way. We found examples were people had DNACPR documents in place and no other supporting care plans to show how their needs and expectations would be managed.

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 good. At this inspection this key question has now deteriorated 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection we recommended the service continued to develop people's records to achieve a consistent standard of detailed, personalised plans. We also recommended the provider review their governance checks. At this inspection further concerns were identified, and the provider was now in breach of regulation.

- People were at risk of receiving poor care because risks to their safety and well-being were not assessed and managed appropriately to protect them from harm.
- Records were not of good enough quality to guide staff on how to meet people's needs safely in a person-centred way. This meant there was a risk care and support provided may be unsafe.
- Processes to determine the deployment of staff were ineffective because records were poorly maintained. People's assessment of dependency was often out of date and inaccurate.
- Systems to assess, monitor and improve the quality of the service had failed to identify and address the issues highlighted in this report. This left people at risk of harm.
- There was a lack of understanding at all levels about roles and responsibilities.
- Systems were not robust enough to ensure learning from incidents was implemented to further reduce risk to people.
- The registered manager had submitted some statutory notifications to the Care Quality Commission. However, we found several incidents of injuries and allegations of abuse that had not been notified. After the inspection these notifications were received.
- Governance arrangements did not promote the provision of high-quality, person-centred care which fully protected people's human rights.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others.

- There was a lack of effective work with other agencies to support people when their health deteriorated.
- Professionals visiting the home told us that relationships with professionals and communication within

the home could be improved. Guidance provided by professionals had not always been appropriately recorded.

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

● There were no systems in place to obtain feedback from people, their representatives or other stakeholders about the running of the service. Some relatives told us there had been no surveys regarding their experiences of the care provided.

● Staff told us there was a lack of support and communication from the provider. Most staff felt they were able to raise concerns with the registered manager. There was mixed feedback about responsiveness to concerns raised. One staff member said, "Don't know the provider; I'm happy to raise concerns with [registered manager] but there's a lack of action."

● There was a duty of candour policy in place. The registered manager was aware of their responsibility regarding this.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and preferences for care and treatment were not assessed effectively. People were not supported with person-centred care and care did not always meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to act within the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Processes were not effective to protect people from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not appropriately trained and

Treatment of disease, disorder or injury

supervised in their roles.

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
Treatment of disease, disorder or injury	There was a failure to robustly assess risks relating to the health, safety and welfare of people. Lessons had not been learnt to prevent repeat incidents. This placed people at risk of avoidable harm. Medicines were not administered or managed safely.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There were insufficient and inadequate systems in place to monitor and improve the quality of the service. Records relating to people's were not well maintained and contained inconsistent and inaccurate information.

The enforcement action we took:

Warning notice