Platinum Care Homes (Stanwell) Limited

Church View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Church View Care Home is a care home providing accommodation, personal care and nursing care to 57 people aged 65 and over at the time of the inspection. The service can support up to 78 people, many of whom may be living with dementia or a learning disability. People live in one adapted building, divided into six separate living areas, each with their own lounge and dining room.

People's experience of using this service and what we found

Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from the risk of abuse and improper treatment. Staff were not deployed effectively to ensure care was delivered in a safe way. Although large parts of the service were clean and well-maintained staff were not always following good infection prevention control. Improvements were also needed with the recruitment processes with staff.

Medicines required some improvements around the recording of 'as and when medicines' and handwritten medicine administration records were not always countersigned by a second member of staff. We have made a recommendation around this. All other aspects of the administration of medicines was undertaken in a safe way.

There was a lack of meaningful activities for people and staff lacked an understanding of people's needs. Complaints were not always recorded or investigated appropriately. End of life care plans however were more detailed since the last inspection.

Quality assurance and governance systems were not always effective in making sure risks to people's safety were managed safely. Staff at all levels had not always been supported to understand and fulfil their expected roles and responsibilities.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or

autistic people.

Based on our review of Safe, Responsive and Well Led:

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
The model of care and setting did not always maximise people's choice, control and independence. People were not considered and involved in the planning of their care.

Right care:
Care was not always person-centred and did not always promote people's dignity, privacy and human rights. People did not always have access to meaningful and person-centred activities.

Right culture:
Ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services lead confident, inclusive and empowered lives.

Rating at last inspection and update
The last rating for this service was Inadequate (published 18 January 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider remained in breach of regulations.

Why we inspected

The inspection was prompted in part due to concerns received about safeguarding incidents and risks associated with people's care. A decision was made for us to inspect and examine those risks and to follow up on action we told the provider to take at the last inspection.

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.

We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well Led sections of this full report.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

Enforcement and Recommendations

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 monitor the service and will take further action if needed.

We have identified breaches in relation to the safe care and treatment, the deployment of staff, lack of meaningful activities, staff being aware of people's care, complaints not being investigated appropriately

and the lack of robust oversight of the care provision at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains 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.

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

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 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.

Church View Care Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Church View Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Church View is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post. However, they were on leave on the day we inspected. Instead we were supported by the provider and assistant manager (manager).

Notice of inspection
This inspection was unannounced.

What we did before the 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. We took this into account when we inspected the service and made the judgements in this report.

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. We reviewed the information of concern we had received to ensure we focused on the appropriate areas during our inspection.

During the inspection

We spoke with four people and one relative to gain their views on the quality of care provided. 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 the assistant manager, provider and nine staff. We reviewed information held in 11 people's care plans, three staff recruitment files, medication records and other paperwork related to the running of the service.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at people's care plans and quality assurance information.

Inadequate

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained 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 our last inspection, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a failure to manage risks associated with people in a safe way. Although some improvements had been made with written records, we continued to find concerns at this inspection in relation managing risks and supporting people safely, the provider was still in breach of regulation 12.

● At the previous inspection we found that people's pressure mattress had not been set correctly based on people's weight. This meant the effectiveness of preventing pressure sores was reduced. At this inspection we found the same concerns. For example, one person's weight was 58.8 kilograms (kg) however their mattress setting was at 75kg. Another person weighed 37.5kg but their mattress had been set at 50kg. Although we did not identify these people had pressure wounds there was a risk they would develop as a result of the pressure mattress not being set correctly.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. At the previous inspection we found staff were not always following good infection control practices and at this inspection we identified the same concerns. Two sluice room (areas for cleaning soiled items or disposing of soiled continence aids) doors had been left unlocked with soiled items in the bin inside. It was evident from the dry sinks that staff had not washed their hands before leaving the sluice room despite there being signs reminding them to do so. The manager told us staff had reminded to do this and were disappointed to find this was still happening. We found the fabric one person's bed bumper and wheelchair was worn which would prevent effective cleaning.
● We were not assured that the provider was preventing visitors from catching and spreading infections. We observed in the afternoon for a period of ten minutes there was no member of staff in reception and the front door had been left on the latch. We saw two visitors enter the home unnoticed by staff. They walked through the home without providing evidence of a negative lateral flow test. This also posed a risk of people leaving the home without staff being aware. We raised this with the manager who addressed this.
● The management of other risks was not undertaken in a safe way. According to their care plan, one person

had behaviours where at times they may throw fire extinguishers and heavy objects. To minimise the risk of injury to themselves and people staff had locked all the fire extinguishers from the unit in the nurse's office. Only the nurse and team leader had the keys to the office which meant if in an emergency staff may not have been able to access the fire safety equipment.

● We observed another person was in their bed and was dropping their legs over their bed frame. As a result, staff told us they had sustained skin tears. Staff had also placed the person's table next their bed and there was a risk the person would further injure themselves on the table. The person's care plan had not considered other alternatives to using a bed rail to prevent the risk of injury such as a low bed.

● Clinical risks were not always being managed in a safe way. In the early hours of the day of the inspection an on-call GP had visited the home. The GP had requested for a person to be admitted to hospital and had called for an ambulance. Staff had recorded on the person's daily care notes that medical intervention from hospital was urgent. An ambulance arrived at the service early evening that same day however the person had not had any clinical observations undertaken by the nurses to ensure their condition had not deteriorated.

● Staff were not always recording incidents when they occurred. We noted from one person's care notes they sustained a skin tear on their right arm from rubbing on the bed rail. This was the same person we saw frequently moving their legs over the bed rail. An incident form had not been completed in relation to this. No other action had been considered to protect the person other than to place a dressing on the person's leg to prevent further injury.

As the provider failed to ensure risks to people's care was managed in a safe way and failed to ensure staff followed good infection control practices this was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse

At our last inspection, we identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found staff had a lack of understanding of safeguarding procedures and what they needed to do if they suspected abuse. People had also raised concerns about how they felt with staff. At this inspection we identified the same concerns and the provider remains in breach of regulation 13.

● There were varying responses from people when we asked if they felt safe with staff. Comments included, "I get on very well with them", "Sometimes they or they're are alright" and "I worry about things but not about staff. They are kind." One relative told us, "He (their family member) calls out to staff as they walk past,

so he obviously feels comfortable with them."
● Prior to the inspection a health care professional raised a safeguarding concern. They had been told by the registered manager that one person required two staff to support them with personal care. The registered manager had advised the health care professional "Two staff help her with personal care one talking to her and holding her while the other helps with personal care." Although we did not see the person being restrained there was a lack of information in the person's care plan around how the person needed to be supported in the least restrictive way.
● Staff told us they would not restrain the person but distract them whilst another member of staff was providing the personal care. There was no recognition from the registered manager that holding the person was a form of restraint.
● Staff were able to describe to us what constituted abuse and the signs to look out for. However as in the previous inspection they were not all aware of who to report concerns to outside of the organisation in the absence of a senior member of staff.
The lack of understanding of safeguarding processes demonstrated a repeated breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not always deployed effectively to ensure people's safety. At this inspection we continued to find concerns and the provider was still in breach of regulation 18.

● There were mixed responses from people around staff levels. Comments included, "Day staff come quickly but night staff not so", "Sometimes we could do with more. Particularly in the morning. Sometimes you have to wait a while" and "There are enough for my needs."
● Whilst we found there were sufficient staff, we found concerns with the deployment of staff which put people at risk. The manager told us one person required to have a member of staff at all times due to risks to themselves and other people when they became anxious. This was funded by the Local Authority. We observed an occasion in the afternoon when the person was without a member of staff being present over a 15-minute period whilst the person was walking around the unit. We asked a member of staff which staff was allocated to the person and they told us, "We all just do it. We help each other."
● Staff were not always appropriately inducted to their role. We observed a new member of staff the manager told us was supposed to be shadowing other staff to get familiar with people's needs. We observed this member of staff spent a large part of the day following and observing a person. They told us staff had told them the person was at high risk of falls and had presented behaviours that were challenging. The member of staff had not been provided guidance on how to support the person if they became anxious.
● In the afternoon on one unit the manager told us there were supposed to be three carers however we only observed one member of staff and another member of staff who was shadowing them. We observed a person in their room was leaning over their bed and looked like they were going to fall out. We pressed the person's sensor mat and staff did attend quickly however they were not aware of this risk until we identified it.

The failure to suitably deploy enough staff who were competent and properly trained for their role was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider did not always operate safe recruitment practices when employing new staff. We reviewed the recruitment file for three staff. One staff member had worked at the service before however they had

been absent for since December 2019. There were no details of the gap in their employment or any recent references. The provider told us the member of staff had been away due to personal circumstances. However, there was no information in the file to explain this.
● On the other two staff files we reviewed there were appropriate references, evidence of identity and full employment histories. There were checks with the disclosure and barring service (DBS) for all three staff. DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Using medicines safely

● People were supported to take their medicines as prescribed. One person told us, "I have it three times a day. It's always on time."
● We found some elements of the recording of medicines that required improvement. For example, there were handwritten entries on the medicine administration records (MAR). They had not been always countersigned by another member of staff to ensure their accuracy.
● There were not always protocols in place for staff for when they needed to offer people 'as and when' medicines. This was particularly important for those people who were unable to verbally express when they were in pain.
● Other areas of the administration of medicines was undertaken in a safe way. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Medicines were safely stored in locked cupboards or lockable fridges if required. There were no gaps on people's MAR.
● Competency checks were undertaken with staff as part of the training process ensure they were administering medicines safely.

We recommend the provider considers how the recommendations of NICE Guidance SC1 apply to the management of medicines in the service.

Preventing and controlling infection
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits to people living at the home in accordance with current guidance. We observed visitors at the service during the inspection.

Inadequate

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; 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

At our last inspection, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not receiving care that was person centred, activities were lacking, and end of life care planning was not in place. Although some improvements with end of life care planning were in place, we continued to find concerns at this inspection and the provider was still in breach of regulation 9.

● At the previous inspection we found people's care plans lacked information regarding their life histories, important people in their lives, and personal preferences. At this inspection we found care plans had been updated however staff we spoke with had not read people's care plans and lacked knowledge around people. One member of staff told when we asked how they would get to know people's backgrounds, "I ask others and they tell me, or I ask the person. This increased the chance that staff may not be responding in the best way to people's individual wants and needs, affecting their overall quality of life.
● People fed back they wanted more activities in the service. Comments included, "It can sometimes be a very long day", "Sometimes I would like to do something different" and "I get bored. Mostly it's the afternoon I get bored." A relative told us, "I've seen very little evidence of activities. I've never come in and found him engaged with something."
● One person's care plan stated they needed to be offered activities including crosswords and reading books. It stated the person should be offered a walk in the garden or in the park on a daily basis to reduce their anxiety. However, staff on the day of the inspection were just following the person and frequently persuading the person to sit down. We heard the person repeatedly ask, "How do I get out?" and despite one member of staff telling them they would take them out this did not take place.
● Another person was cared for in bed and their care plan stated they 'require sensory activities to help her with sense of touch, hear, sight and vision'. We did not see any sensory items in the person's room and engagement from staff was limited to when staff brought the person their meal. A member of staff told us of

activities for people who were for care for in bed, "Sometimes they [activity staff] come and do activities. We will sometimes visit them when we have time."

● Staff had not always considered the sensory needs of people that were living with dementia. On one unit we found the radio in the lounge was playing loudly and staff had to shout to people to be heard. The music playing was modern pop music whilst the television was also on silent with sub-titles which could be confusing for people living with dementia. When we spoke with staff about this, they lacked an understanding of why this would be confusing to people living with dementia.

● On another unit a member of staff was trying to get a person to play with a beach ball. You could see the person was not engaged with this. However, the member of staff kept persisting, repeatedly saying the person's name which continued for 20 minutes. The member of staff did not consider the person may not have understood the game and offer a more person centred and meaningful activity.

● Another person was in bed on the day of the inspection. Their social care plan stated staff should spend quality time with them chatting, playing ball games, dart board games, popping out bubbles, games and play country music. We did not observe any of these activities taking place and there was no music or television playing in their room. We also observed the person's air mattress was making a loud vibrating noise. When we raised this with the manager, they stated the machine was working properly but had not considered the discomfort to the person from having to hear this constant noise.

● We observed another person in bed was distressed and was expressing their feelings about their husband who had passed away. Their care plan stated the person experienced depression and staff should spend time with them and provide reassurance. However, we did not observe staff spending any meaningful time with the person. We heard the person say to a member of staff, "Is my husband coming?" The member of staff replied "hopefully my dear" but then left the room without offering any further comfort.

● Staff we spoke with lacked an understanding of the care required for people living with dementia. One member of staff told us, "Mentally it's hard to talk to them" despite the training record showing they had received this in February 2022.

The lack of person-centred care and providing meaningful activities to meet people's needs was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Staff had not always considered people's individual needs to communicate with people in ways they understood. We did not observe staff using accessible ways to communicate with people during our visits.

● One person did not speak in English. Their care plan stated staff were to learn their non-verbal communication but gave no description of what this was or how to respond. We asked a member of staff if staff had tried using any communication aids including online translation, photos or pictures. They told us this had not been considered as they relied on the person's gestures to communicate their needs. Two members of staff told us they were able to speak in the person's language however when they entered the person's room they spoke in English.

The lack of consideration of people's needs and preferences relating to their communication was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Improving care quality in response to complaints or concerns

● At the previous inspection we recommended that records should be made of whether complaints had been resolved to the complainant's satisfaction. We found this had not improved.
● Prior to the inspection we were made aware of complaints made by relatives about their family members care. As a result of not receiving a response from the staff at the service the relatives raised this with the Local Authority. When we reviewed the folder, these complaints were not recorded and there was no record of what actions had been taken.
● There were two complaints that we saw had been raised. One in the complaints folder and one we had been copied into via email, both from relatives. The registered manager had responded to both complaints but there had been a delay in the outcomes. There was no explanation as to why there was a delay and no apologies given around the length of time the relative had to wait for a response.

As complaints were not always recorded and responded to without delay this is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● At the previous inspection we found there were no end of life care plans in place. At the latest inspection we found this had improved. The manager told us they had been working with relatives to get information on what was important to their loved ones. We observed a relative providing this information to the manager on the day of the inspection.
● Information in the care plans included people's spirituality, religion, what family they wanted around them and where they wanted to be at the end of their life.

Inadequate

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating has remained 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.

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; Continuous learning and improving care

At our last inspection we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to mixed feedback from people and relatives about the management of the service. It was also due to a lack of robust oversight of the service. We found similar concerns at this inspection in addition to identifying new breaches of regulation. The provider remains in breach of Regulation 17.

● Since the last inspection there were repeated breaches of regulations and additional breaches had occurred. This placed people at risk of harm to their health and well-being.
● People we spoke with were not aware of who the registered manager of the home was. Comments included,
"I don't know who the manager is. I don't have a lot to do with them to be honest" and "I don't know the manager."
● Relatives had been asked to complete surveys about the quality of care. Although there were positives comments about the caring nature of staff, there were concerns around the lack of communication. Some relatives had suggested that the service social media page could be used to share messages about the home including visiting restrictions. No action had been taken by the provider to take these suggestions on board.
● People had completed surveys in February 2022 and where feedback around improvements had been suggested these had not been considered or action taken. This included suggestions around more activities and more fresh fruit and vegetables to be provided.
● There were positive comments from staff about the leadership with one telling us, "Managers are both

nice." There were also positive comments shared by staff on the recent survey completed by the provider. However, we saw from surveys undertaken that staff did not always feel valued and listened to. There was no action plan as a result of the survey to show what action they were taking to address this. One member of staff told us, "If any ideas are brought to [registered manager] they won't listen to it."

● The internal quality assurance systems and processes to audit or review service performance and the safety and quality of care were not adequate. Although there was a system of audits undertaken by staff these had not always identified or prevented issues occurring or continuing at the service.

● We reviewed a 'Dignity' audit from February 2022 where it stated staff were offering social and leisure activities to people that where person centred and age appropriate. However, this was not evident from our findings or based on feedback from people and relatives. A senior member of staff told us, "We discussed activities last week and we can improve."

● Where shortfalls were identified from audits sufficient action had not been taken as a result. We noted from a health and safety audit in February 2022 staff were leaving the sluice room doors unlocked. We found this was still occurring on the day of the inspection.

The failure to ensure quality assurance and governance systems were effective service and performance was evaluated and improved was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● After the inspection the provider told us they were commissioning a company to undertake audits every two months at the service.

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

● The registered manager had not always ensured they had shared information with relatives regarding unsafe care and service users being harmed whilst receiving support with regulated activities. We were made aware by the Local Authority of incidents where relatives raised concerns with them. This included where their family members who had sustained injuries and they had not been contacted by the staff at the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others

● During the inspection we found there was a lack of knowledge of people's needs from the management team. Neither the assistant manager nor clinical lead were able to give a clear picture of people's needs throughout the home.

● There was a lack of oversight and leadership on each of the units at the service. Although there were recorded allocations to assign roles to staff throughout the day, staff were either not aware of this or not following this. For example, according to the allocation sheet one member of staff had been allocated to be a person's one to one. Staff we spoke with told us that no one was allocated to the person and they all shared this role.

● Staff that were on their shadow shifts and were not allocated to provide care were assigned a specific member of staff to shadow. However, we saw frequent occasions where they were either observing a person walking
around or were sat down with people whilst other staff on duty were continuing with their tasks.

● Where the service was required to send the CQC notifications these had not always been submitted. We were made aware of instances of alleged abuse and neglect that had been raised by health care

professionals and relatives that the registered manager had been notified of. However, these had not been notified to the CQC as required

● The provider was not always working effectively with partner agencies. During the inspection a GP was visiting the service. Staff had not asked the GP to check on the person who had been waiting for an ambulance due to urgent treatment being required. Another visiting health care professional fed back that a timely referral to the Mental Health Team had not taken place for a person that was displaying increased anxiety.

The failure to ensure there was robust oversight of care and the service worked in partnership effectively with other agencies is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There were healthcare professionals who told us staff were good at contacting them for advice and had worked well with them to help people when there had been safety incidents. This was also evident is some health care professional feedback notes left at the service.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to send notification to the CQC where appropriate.

The enforcement action we took:

We cancelled the providers registration

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 The provider failed to ensure there was adequate person-centred care and there was a lack meaningful activities to meet people's needs.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people's care was managed in a safe way and failed to ensure staff followed good infection control practices.

The enforcement action we took:

We cancelled the providers registration.

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

	The provider failed to ensure staff had an understanding of safeguarding processes.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure complaints were always recorded and responded to without delay.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that quality assurance and governance systems were effective and performance was evaluated and improved.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were suitably deployed and staff were competent and properly trained for their role.

The enforcement action we took:

We cancelled the providers registration.