Susash Sheffield Ltd

Cambron House

Inspection report

3 Flanderwell Lane
Bramley
Rotherham
South Yorkshire
S66 3QL

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18 December 2020

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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
Cambron House is a care home providing personal care and nursing. It can accommodate up to 38 people. There were 22 people using the service at the time of the inspection.

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

The service had no registered manager and systems and processes used to ensure the service was running safely were not robust or effective.

Risks associated with people's care were not always identified or managed in a way that kept people safe.

Staff were not always deployed effectively to ensure people's needs were met. Staff had not consistently received specific training to meet people's needs. Staff did not receive competency checks on their performance and abilities to ensure they carried out their roles and responsibilities safely.

The provider had a recruitment process in place which showed staff were recruited safely. However, monitoring of poor performance needed improving.

There were systems in place to safeguard people from abuse. However, these were not effective and following our inspection, we referred seven safeguarding concerns to the Local Authority.

We identified shortfalls in the way people's medicines were managed.

People were not always protected by the risk and spread of infection.

Staff did not support people appropriately; their approach was not always person-centred and at times was task orientated. Staff did not always respect people's privacy and dignity.

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 not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

There was lack of evidence to show that people were involved in decisions about their care, support and treatment. Relatives we spoke with told us there was lack of communication during the pandemic.

People told us the food was nice. However, from observations it was not clear that people had choices. We identified some people had significant weight loss, therefore it was not always clear that people's nutritional needs were met.

The environment was not appropriate and did not meet best practice in supporting people living with dementia.

Complaints were recorded in line with the provider's policy. However, not all concerns had been documented and dealt with following the policy, to evidence what actions had been taken to minimise issues reoccurring.

End of life care plans were in place, but they did not always identify people's preferences and choices.

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 16 November 2018)

Why we inspected
The inspection was prompted due to concerns received from the local authority commissioners and safeguarding referrals. These were regarding, risks not being managed and lack of robust infection prevention and control. There had also been an outbreak of COVID-19 in the home. Initially, we completed a site visit to look at the Safe and Well led key questions. Following the concerns, we identified at this visit, we completed a second site visit to include the key questions of Effective, Caring and Responsive.

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 coronavirus and other infection outbreaks effectively.

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

We have found evidence that the provider needs to make improvement. Please see all sections of this full report.

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

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

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 safe care and treatment, consent to care and treatment, person centred care, staffing, leadership and oversight 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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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.

Cambron House

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 CQC's response to care homes with outbreaks of coronavirus, we as part of this inspection conducted a review to ensure that the Infection Prevention and Control (IPC) practice was safe and the service was compliant with IPC measures.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience, who carried out telephone calls to relatives of people using the service. This was completed off site. 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
Cambron House 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.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is 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 the inspection
We reviewed information we had received about the service since the last inspection. We received 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 providers are required to

send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and 12 relatives via the telephone about their experience of the care provided. We spoke with twelve members of staff including the provider, manager, deputy manager, clinical lead, nurse, care workers, ancillary staff and the maintenance person. 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 reviewed a range of records. This included six people's care records, medication records and weight records. We looked at two 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 training data and quality assurance records. The provider also submitted an action plan following our feedback.

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 good. 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

- Risk to people were not suitably assessed or managed. For example, we found risk of weight loss was not addressed. People had lost weight, and this was not monitored or reviewed to ensure staff were following advice from health care professionals.
- People were not moved and handled safely. We observed unsafe practices when staff were supporting people to move from the chair to a wheelchair, putting people at risk of harm.
- Peoples records were not up to date. We identified food and fluid charts were not properly completed and did not accurately reflect what people had eaten or drunk. This meant they could not be effectively reviewed.
- Accidents and incidents were not effectively analysed, therefore, any themes or trends were not identified to mitigate risk and ensure lessons learned.
- Environmental safety checks were being carried out. However, we found the communal lounge was very cold. On the first day of our inspection, the thermometer was recording 15 degrees centigrade. We discussed this with the manager who organised portable heaters. This had been rectified by the provider when we visited on 11 December 2020.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medication systems were in place to ensure safe management of medicines. We found the clinical lead had improved the processes. However, we identified there was no clear guidance for staff on when to administer medicines that were prescribed on an "as required" basis, (often referred to as PRN). Some protocols were in place but did not give adequate information. For example, where people lacked capacity to communicate with staff the protocols did not explain how the person presented when they were in pain, so staff were not able to determine when they required pain relief. Therefore, people may have been in pain and not received their medication.
- Administration of as required medicine were not always recorded following best practice. For example, when pain relief was administered, staff did not record what pain the person had described and did not record if the pain relief had been effective. Therefore, it was not possible to review to ensure the person was pain free.

The provider had failed to ensure the proper and safe management of medicines which is a breach of regulation 12 (Medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The environment was predominantly clean, however, there was only one domestic and they were struggling to ensure all deep cleaning was carried out. Therefore, we found areas of the home had malodours and were not thoroughly cleaned. We also found many areas required improvements to ensure it could be cleaned effectively. This was being addressed by the provider but not always in consultation with people who used the service.

● People were not always protected from the risk of infection. Staff were seen following the new guidance regarding personal protective equipment (PPE) in relation to the Covid-19 pandemic. However, on occasions we saw staff not wearing PPE properly, not washing their hands as frequently as required, not following best practice and found clinical waste bags stored on bathroom floors, PPE discarded outside the rear exit and external waste bibs overflowing, which increases the risk of cross infection.

The provider had failed to ensure the proper and safe infection, prevention and control which is a breach of regulation 12 (Infection prevention and control) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not always sufficient numbers of staff available to meet people's needs. We observed lack of leadership and direction, which meant the deployment of staff was ineffective to meet people's needs. For example, we observed staff go outside together leaving communal areas unattended. Since our inspection the provider has increased the staffing levels to ensure people are safe.

● Staff did not receive effective training. There was not always the right mix of skills and competencies of staff on duty. For example, we observed staff did not follow safe practice when moving and handling people when providing support. The training they had received was not effective. This was addressed by the provider and training has been provided to all staff following the inspection.

The provider had failed to ensure there were skilled and experienced staff deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a staff recruitment system in place. Pre-employment checks were obtained prior to staff commencing employment. These included at least two references, and a satisfactory Disclosure and Barring Service (DBS) check. A DBS check provides information about criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the service.

Systems and processes to safeguard people from the risk of abuse

● There were systems and processes in place to safeguard people from abuse.

● Staff told us if they had concerns that a person was being abused, they would report it to their line manager. However, this was not what we found. We identified seven safeguarding incidents during our inspection and have made referrals to the local authority safeguarding. The provider had failed to identify, or act upon, these concerns.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's physical, mental and social needs were assessed, however, their care, treatment and support was not delivered in line with legislation, standards and evidence-based guidance, to achieve effective outcomes. For example, effective support was not in place to assist people living with dementia to communicate and promote their independence.
- People's care plans we looked at did not include people's preferences and choices.

Staff support: induction, training, skills and experience
- Staff did not receive effective training to meet people's needs and to carry out their role effectively. For example, the training records showed staff had received moving and handling training. However, we observed on both days of our visit poor, unsafe moving and handling of people, which put them at risk of harm.
- Staff did not receive effective training, support or competency checks that ensured the service was person-centred. Person-centred planning is an empowering approach to help people achieve their goals and to live the life they want. It helps people to plan and organise the systems and support they need to lead a life that makes sense to them. To support a person-centred approach, staff need to have effective training, support and values. For example, we observed staff being task orientated and practices were institutionalised.
- Staff were not supervised to ensure they fulfilled their roles and responsibilities and kept their professional practice and knowledge updated. We saw supervisions were generic and where the manager had identified poor practice this was not addressed with the staff member.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive care and support from suitably trained and skilled staff.

Supporting people to eat and drink enough to maintain a balanced diet
- We looked at care records in relation to dietary requirements. We found people were not always supported to maintain a healthy balanced diet which met their needs.
- We identified weight loss, therefore it was not always clear that nutritional needs were met.
- People we spoke with told us the food was nice. However, from our observations it was not clear that people had choice. There were no picture menus to assist with choice and people were not shown alternatives to be able to make a decision.
- People were not appropriately supported at meal times. We observed people were brought into the dining room and left unsupported. We observed people taking food from the person sitting next to them and

sharing cutlery. Staff had not ensured there was adequate cutlery when the meal was served. We observed another person banging their cup on the table. No care worker was in the dining area and seven people were left unattended. We asked the nurse where the care staff were, and they did not know. When the staff did appear, we asked them where they had been, they told us they had been turning people who were in bed. This showed lack of coordination and deployment of staff to ensure people's nutritional needs were met and the mealtime experience was positive.

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

● Staff did not always seek support from health care services to ensure effective timely care. For example, one person had deteriorated, and they were no longer able to weight bear, the staff had not sought advice from health care professionals or made a referral requesting an assessment.

● People were not supported to live healthier lives. We found several people had lost considerable weight. There was no monitoring of their food intake, no referral to a dietician and no review of their care plan to ensure they received adequate nutrition.

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

● The environment was not appropriate and did not meet the best practice guidance in supporting people living with dementia. The décor was bland and there was a lack of pictures, signage and tactile objects.

● There were some improvements to the environment, however, these were not in consultation with people who used the service and were not homely in style.

● People did not always have access to a call bell. We found during the tour of the building that in many rooms', beds were placed away from call bells so were not accessible to people when they were in bed. We discussed this with the deputy manager who told us people were unable to use the call bell. One relative raised concern with us regarding lack of access to the call system. They told us, "[Relative] had fallen and was unable to reach the call bell that was fixed to the wall."

This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person-centred care which met their needs

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 provider was not always working within the principles of the MCA.

● Where decisions had been made on behalf of people, they had not always been completed in the person's best interests. We saw relatives were consenting on some instances when they did not have the authority.

For example, one person's relative had made decisions that had been agreed that were dated three years previous and the relative no longer visited, yet these decisions were still in place.

● People's wishes were not considered. People were deprived of their liberty. For example, keeping them isolated in their bedrooms, with no clear reason why.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not always working within the principles of the MCA

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; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity.
- We spent time observing staff interacting with people. We saw staff did not always engage with people when providing care and support and were task orientated.
- People living with dementia were not supported in a meaningful way to enable them to express their views. We saw staff stood observing people in the dining room and not interacting or providing encouragement to eat. There was no visual stimulation and best practice was not adhered to such as appropriate use of colours, pictures and tactile objects.
- People's choices or wishes were not detailed in their plans of care. Peoples preferences were not considered as part of their care and support. For example, one person's religious needs were clearly recorded in their plan of care, but they had had not had their religious needs met. Another person's care plan stated they liked to be with people and be involved in activities, yet the staff had made the decision to keep them in bed, which was socially isolating them.

This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person-centred care which met their needs

Supporting people to express their views and be involved in making decisions about their care
- During our observations we saw people were not involved in decisions about their care. Staff did not always explain the tasks they carried out.
- Care plan documentation did not reflect that people had been involved in creating and updating them.

Respecting and promoting people's privacy, dignity and independence
- We observed staff did not always respect people and did not always promote privacy. At times we saw staff had a lack of regard for people's privacy and dignity. For example, we saw one person had just been supported to eat their meal in bed, the persons clothes and sheet were extremely wet from a spilt drink, they had been left in this state by the staff.
- People's independence was not always promoted. For example, staff did not support or encourage people to do things for themselves.
- The service did not always ensure they maintained their responsibilities in line with the General Data Protection Regulation (GDPR). GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. We saw people's records were stored in communal areas,

which meant confidentiality was not always maintained.

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. Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive person-centred care which met their needs and preferences.
- Care records we saw did not contain enough detail to ensure care was delivered in a consistent way and in line with people's choices and preferences. Care records did not reflect peoples care and support required. They, were not updated, reviewed or evaluated effectively to ensure people's needs were met safely. For example, one person liked to sit in the lounge to engage with other people, yet they had been left in bed.
- The provider had identified the care records required improvement and was arranging training for staff. This was to enable staff to review and re-write the care plans, to ensure people's current needs were identified and they were person centred.
- People were not always supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them.
- The provider had recently employed an activity co-ordinator to improve people's access to social stimulation and prevent isolation. The activity co-ordinator was available Monday to Friday and alternate Sundays. The hours worked were flexible depending on activities arranged. They told us they were still getting used to the home and said, "I'm still getting to know people."
- We observed staff interacting with people and saw they were task focused. For example, people were brought into the dining room left unattended not offered a drink while they were waiting. People who were nursed in bed were all turned at set times was not individualised, people were weighed together on the same day in the communal lounge. The support provided was not in line with people's choices, needs or preferences.
- People and their relatives we spoke with also raised concerns that care was not person centred. For example, one relative who had done window visits said, "I noticed that [my relative] was not wearing their own clothes and that they required a shave. They have always been particular about their appearance, so this was unnatural."
- There was a lack of alternative communication systems during the pandemic to support people to maintain relationships. The provider had failed to provide alternative effective communication methods.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always provide person-centred care which met people's needs and preference.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●We found these standards were not always followed. Staff did not communicate effectively with people and there was lack of information in a format that people living with dementia could understand. During our observations we found staff did not use accessible information to enable people to communicate effectively. For example, at the meal time there were no picture cards to assist people with making choices.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure.

● We saw the manager kept a record of complaints. However, they had not documented all the concerns received. Therefore, it was not clear if people were listened to and that appropriate action had been taken.

● Some people and their relatives we spoke with told us they did not feel listened to. They also commented there had been very limited communication during the COVID-19 pandemic.

End of life care and support

● People had end of life care plans, but they did not always identify people's preferences and choices.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service did not have a registered manager. The provider had employed a manager, who had commenced in September 2020, however, they were not registered with the CQC.
- The staff were not clear about their roles and responsibilities and did not understand the regulatory requirements. Staff told us they had not always felt supported and felt there had been lack of leadership and guidance. Staff acknowledged the changes in manager and the new management team now in place had impacted on this. One staff member said, "We get a new manager, and everything changes again, lack of consistency, we now have a new team to get to know."
- There had been a lack of provider oversight. However, they acknowledged the service needed to improve and since our inspection have provided an action plan to ensure improvements are made and embedded into practice.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider did not ensure that people received person centred care. Support we observed was task focused and institutionalised. For example, staff did not engage to ask peoples preferences or choices.
- Outcomes for people were not met. For example, people's mental health needs were not met. We observed the care workers sitting in the communal areas with people, however, they did not engage. Staff did not communicate or interact with people, they were seen writing care notes or talking to each other.
- Staff did not work together as a team. We observed there was no clear leadership and the staff team did not work together. This meant staff were not deployed effectively to meet people's needs, therefore, not achieving good outcomes for people.
- People did not feel listened to. The provider did not always promote a positive, open and inclusive culture. One relative we spoke with told us they had not been listened to. They had raised a concern that their relative was often visited at night in their room by other residents. When they had raised this, they were very unhappy at the response. They told us the member of staff said, "This is an EMI home and such behaviour must be expected. It was your choice to send them here." This concern was not documented in the manager's complaints' record.

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 service did not always show honesty and transparency from all levels of staff and leadership. We

identified issues that had not been reported. For example, considerable weight loss, poor moving and handling practices, poor performance and safeguarding concerns. The provider had not fulfilled their duty to inform the relevant bodies. The manager has done this retrospectively, once they were made aware and are as part of their action plan will retain staff and performance manage to drive improvements.

Continuous learning and improving care

● Systems in place to monitor the service were not effective. Quality monitoring had taken place but had not always identified issues we found. For example, the environmental audit had not identified all the shortfalls we found.

● We looked at the audit in relation to managing weight loss. We found there were a number of weight records, there was no consistency and no effective oversight of weight loss and actions required. Therefore, the audit was not effective in driving improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives we spoke with told us the communication had been poor during the pandemic. They felt they were not always kept informed or involved in the care and support of their loved ones. Due to the current COVID-19 pandemic there were restrictions on visiting yet no other methods of communication had been put in place.

Working in partnership with others

● The provider did not always engage with healthcare professionals. We found that advice was not sought when people's needs changed. The local authority had raised previous concerns prior to the pandemic, and they had found the same concerns when they visited seven months later. Therefore, the provider had not effectively engaged with partners to ensure improvements. This is being addressed by the provider.

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.

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 The provider did not ensure people received care that was person-centred, individualised, met their needs or preferences.

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 The provider did not ensure care and treatment was provided with the consent of the relevant person.

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 did not ensure risks were managed, did not have systems in place to manage infection, prevention and control and did not manage people's medication effectively. This put people at risk of harm.

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 did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not ensure systems were operated effectively to ensure improvements in the quality and safety of the service provided.

The enforcement action we took:

We have issued a Warning Notice.