Rylands Residential Limited

Ryland Residential 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?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

AAbout the service
Ryland Residential Home is a residential care home providing personal care for up to 17 people. The service provides support to older adults. At the time of our inspection there were 16 people using the service.

People's experience of the service and what we found:
The provider failed to have sufficient systems and processes to assess, monitor and mitigate the health, safety and quality of the service. Their quality assurance systems failed to identify people were at risk of harm from lack of risk assessments, plans to mitigate risks and lack of adherence to policies and procedures.

People were at risk of infection and harm from a service which was unclean and required repair and refurbishment.

The provider, registered manager and staff did not understand their roles in safeguarding people. Incidents of alleged abuse were not recorded or reported to the local safeguarding authority. Medicines were not managed in line with best practice. Staffing levels were not safe and left people at risk of falls and social isolation.

People's specialised diets were not followed or planned effectively. The provider did not work well with professional agencies to mitigate risk and improve outcomes. Staff had not received relevant training to support them to be competent in their roles.

Care was not person-centred and was task oriented. People were not always treated respectfully or with dignity. People did not receive personalised activities and were left at risk of social isolation.

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 people to live in the least restrictive way possible.

People were supported to have contact and visits from relatives. Staff recruitment was safe. Some staff showed a caring and compassionate attitude. Relatives told us they felt the service was safe, person-centred, and meals were of good quality. Relatives felt the registered manager was friendly and approachable.

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 the service under the previous provider was Good (published 17 November 2017).

Why we inspected
The inspection was prompted in part due to concerns received about medicines management, staffing levels and the environment. A decision was made for us to inspect and examine those risks. We made a decision to complete a comprehensive inspection due to the change of service provider since the last inspection.

Enforcement
We have identified breaches in relation to safety, safeguarding, person centred care, staffing and training.

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, which will help inform when we next inspect.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well led. Details are in our well-led findings below.	**Inadequate**

Ryland Residential 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.

Inspection team
The inspection team consisted of 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Ryland Residential 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. Ryland Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are

required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also reviewed information shared with us by the local authority. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people and 8 relatives. We also 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 7 staff members. This included kitchen, housekeeping, and care staff. We spoke to an external professional visiting the service. We also spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We completed observations of people being supported by staff and the service environment. We reviewed a range of documentation including people's care plans, medicine records, staff recruitment files, training records and manager audits.

Inadequate

Is the service safe?

Our findings

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

This was the first inspection of this service under the new provider. At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed 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

- Risks to people experiencing falls had not been assessed and mitigated safely. People had sustained injuries from frequent falls. Threshold strips in doorways and carpets not flush to the floor presented a tripping hazard for people. During the inspection, a person had an unwitnessed fall. Staff were observed to not complete immediate safety checks for this person, placing them at risk of unidentified injury. As the person indicated they were experiencing pain, the inspector prompted staff to contact the registered manager, who attended the incident. The registered manager completed relevant checks and contacted healthcare professionals.
- Risks relating to people's medical conditions were not assessed and mitigated safely. People living with diabetes did not have care plans with information about how staff should recognise and support people if their condition deteriorated. One person was recorded as requiring a diabetic-friendly low sugar diet but food records showed this had not been followed. This left the person at risk of an adverse reaction due to their condition.
- People were at risk of skin damage as their skin integrity risks were not managed safely. One person did not have risk assessments or a plan of care to mitigate the risks of their existing pressure sores deteriorating. This person was observed to be left without appropriate support to reposition to relieve the pressure on their skin for a prolonged period and this increased the risk of further skin damage. Staff were not recording when they repositioned people consistently, placing people at risk of deterioration of existing pressure damage and/or developing a new pressure sore.
- People were at risk of harm from environmental factors as risks were not mitigated. Hazardous items were accessible to people who may not have understood the risks associated with them. An unlocked set of drawers contained disinfectant and button batteries, which could have caused serious harm if ingested. Windows were not restricted in line with Health and Safety England guidance, which states windows should be restricted to opening 100mm. This left people at risk of falling from height. Wardrobes were also not always secured to walls, which presented a risk of injury caused by the wardrobe falling forwards, especially for those people who used furniture to support mobilising.
- Lessons had not been learned following incidents. For example, documented falls did not include any investigation, risk mitigation or lessons shared following the incidents to reduce risk of reoccurrence. People's behaviour charts had not been reviewed to gain learning to mitigate future risk and impact on people. Relevant professional referrals had not been made or followed up to improve people's safety.
- Fire risks were not always managed safely. Personal emergency evacuation plans (PEEPS) were not always up to date to help safe evacuations in the event of an emergency. For example, a person was recorded to be residing in a different bedroom to that stated on their PEEP which put them at risk of not being evacuated safely if required.

Using medicines safely

● Medicines were not always managed safely.

● Staff did not always complete administration records when they administered topical creams. A person who was known to have a prescribed cream for identified sore areas did not have administration recorded and there was no evidence they had received their cream as prescribed. This left them at risk of further skin breakdown.

● Staff did not store or check the labels for prescribed creams in line with best practice. Prescribed creams were accessible in people's rooms; there was a risk that people may not have understood their use and creams could be ingested. Creams were also found to not have legible labels, so it was unclear when they and been opened and if they were still effective in line with manufacturers guidelines.

● People's 'as needed' medicines did not always have protocols in place to inform staff when they should be given, and this was not in line with best practice.

Preventing and controlling infection

● People were not protected from the risk of infection. Areas of the service were damaged and unhygienic. For example, the laundry room had widespread damage to a wall following a previous leak and this made the surface difficult to clean and risked the harbouring of bacteria. The kitchen also had exposed brickwork where food was stored in close proximity, and this risked food contamination. Once raised to the provider by inspectors, action was taken to repair parts of the laundry room.

● Items of furniture, flooring and walls were not always intact and clean. Two mattresses had damage and chairs had significant staining under cushions. This increased the risk of the spread of bacteria. Damage to walls and floors had not been repaired and this made them more difficult to clean.

● The service had a garden area with grass which had several piles of animal faeces, making it unsafe for people to access the garden and a risk of contaminated footwear when returning to the building.

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

● The provider acted to put risk assessments in place where this was highlighted by inspectors. People's 'as required' protocols and secure storage for creams were also put in place following this being highlighted by inspectors.

● Most people and relatives we spoke with felt the service was safe and clean.

Systems and processes to safeguard people from the risk of abuse and avoidable harm

● People were not safeguarded from abuse and avoidable harm.

● The registered manager and staff did not understand how to safeguard people, or the need to report incidents for further investigation. For example, during the inspection an alleged incident of abuse took place. Staff and the registered manager failed to recognise abuse had taken place, record this as an incident or report to the local safeguarding authority until this was prompted by inspectors. This left a person at continued risk of abuse and harm.

● The provider had also failed to report and investigate several unwitnessed falls where people had sustained injuries as well as unexplained injuries recorded on body maps for people. This again left people at risk of continued harm.

The provider failed to have systems in place to protect people from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing levels were not safe. The provider failed to ensure there were enough staff to meet people's needs and mitigate risks. For example, there were 2 staff members deployed on early and night shifts, but there were multiple people who required 2 staff members to support them. This meant whilst these people received their care, there were no staff deployed for other people who required support or supervision to mitigate the risk of falls.
● Staff were not appropriately deployed to mitigate risks to people. During the inspection. a person who was known to be at high risk of falls was found on the floor in a communal area by staff. This was unwitnessed as no staff were supervising this area. This left the person, and others at risk of falls at risk of injury.

The provider failed to ensure sufficient numbers of staff were deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback the provider increased staffing numbers to 3 on the early shift to help mitigate risk in the day.
● Staff were recruited safely. Inspectors identified a staff member with some unexplained gaps in their employment history, but the registered manager sourced this information immediately.
● Staff had relevant recruitment checks in place. Staff files we reviewed included up to date Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in Care Homes
People were able to receive visitors without restrictions in line with best practice guidance.

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.

This was the first inspection of this service under the new provider. At our last inspection we rated this key question Good. At this inspection the rating has changed 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

- The provider did not work in line with MCA.
- People were being deprived of their liberty without legal authorisation in place. For example, people at the service had sensor mats in place which alerted staff to when they got out of bed and this restricted people's liberty. This required either legal authorisation through a DoLS or consent from people if they were able to give it, but these were not in place.
- The provider had failed to ensure mental capacity assessments and best interest decisions had been completed to support decision making for people.
- The least restrictive option was not always taken in line with the MCA. For example, a person had authorisation from the GP to receive covert medicines. These are medicines which given to people without their knowledge as they may refuse to take them. This authorisation stated administration should be attempted twice non-covertly and covert administration was a last resort following this. A staff member was observed to not follow this practice and administered medicines covertly at the first opportunity which was not the least restrictive option.

The provider failed to ensure people were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection feedback, the registered manager made 10 DoLS applications for people who had restrictions to their liberty.

Staff support: induction, training, skills and experience

● Staff were not supported to have the training and skills required to be effective in their roles.
● The provider failed to provide training in relation to people's medical conditions. For example, staff had not received training in diabetes, epilepsy, Parkinson's disease and mental health. This meant people were at risk of not being supported appropriately.
● Staff did not have the skills to manage falls effectively. Only 2 of 19 staff members had received training in falls. Records showed that 4 people were at high risk of falls. Staff were not always competent with responding to falls. Two staff members disclosed staff had 'picked people up' following falls at the service. This meant people were at risk of not receiving appropriate support and further harm following falls.
● The registered manager did not have a system to regularly check staff's moving and handling competencies once staff had completed their training.

The provider failed to ensure staff had received appropriate support and training to fulfil their roles. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following concerns about training being raised by inspectors, the provider began to source and book training for staff in identified areas.
● Staff had received an induction and there was monitoring of performance through, for example, supervisions and medicines competencies.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet;
● People's needs were not always documented accurately to ensure consistent support. For example, staff did not have all the relevant information about people's diabetes management; what to look out for when blood sugars were too high or too low and the relevant action to take. Staff did not have information they required to support people living with a urinary catheter.
● As outlined in the safe key question, people's specialist diets were not always followed. Kitchen staff did not have up to date information about people's diets readily available to ensure their needs were met.
● People's weight was not always monitored safely. For example, a person's weight had not been recorded for over 5 months due to the person refusing to be weighed. An alternative method of recording the person's weight had not been sought and this left them at risk of unmonitored weight loss.

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

● Relatives told us they felt the meals provided were of good quality. People were given choices for their meals but lighter options were not always available.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals were not always made to professionals to help mitigate risks effectively. People who had experienced falls and injuries had not been referred to professionals for specialist input to help mitigate this risk. Where referrals had been made, these had not always been followed up when the allotted response timeframe had passed. This left people at risk of not receiving effective support.
● There was some evidence of health professionals being contacted following incidents, but outcomes of this were not always recorded clearly.

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

● The service was not always adapted, designed and decorated to meet people's needs.
● Several areas of the service, including bedrooms, were outdated and required refurbishment and decoration. For example, there was staining on walls and bed sheets, and carpets required a deep clean. Furniture in bedrooms had visible damage, with one set of draws heavily chipped and another with a handle hanging off which would have made it difficult to use.
● People's bedrooms were inconsistently personalised with people's possessions and photos. People had a care summary chart on display in their rooms where their needs, likes and dislikes could be recorded. These were often not completed or could not be easily read.
● There was a garden area for people, but this was overgrown and in need of maintenance. There were disused items on the exterior of the service such as a used chair in the garden.
● Signage for people was inconsistent and this did not always aid people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This was the first inspection of this service under the new provider. At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

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

- People were not always treated with dignity and respect.
- Language used in care records was not always respectful. This was evident in behaviour charts and daily care notes. For example, people were described as 'aggressive', 'rude' and a person was described in a behaviour chart as, 'having a face like thunder'.
- People's dignity was not always protected. For example, a person had a cream for sore skin stored with their toothbrush in a glass. This tube resembled a toothpaste tube and risked the person using this to clean their teeth. Another person had blinds which did not fully cover their windows, which put their dignity at risk and did not adequately keep light out of their room. Only 2 out of 19 members of staff had received dignity training.
- Staff did not always find time to speak to people to have long meaningful conversations. A person who was observed to have reduced social interaction from staff expressed low mood.

The provider failed to ensure people were always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the provider had increased the staffing levels by one staff member in the mornings; staff told us this had improved the amount of time they could spend speaking with people.
- People's independence was not always promoted. Signage to support those living with dementia or confusion to move around the service was not always in place. Some people's bedrooms and communal areas had signs, but others did not. The provider told us that some signs were missing due to decoration taking place.
- Some staff did show kindness and compassion. Some staff expressed knowledge of people's preferences and relatives felt staff were caring and treated people with dignity. A relative told us, "I would say the staff are very caring, they approach people in a nice way with individual care, respect and dignity."

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

- People who had difficulty expressing their own views were not always supported with decision making. For example, a person had an allocated independent advocate who had not been contacted for over 2 years even though the advocacy service was available to support people to express their views in care reviews.
- While relatives told us people's views and choices were respected it was not always clear when families or people had been consulted about decision making as this was not always recorded. For example, people

with sensor mats in place did not always have documented conversations or best interest decisions involving their families. The registered manager told us they would ensure interactions with families would be recorded in future.

● Staff were observed to offer people choices, such as meals, drinks and snacks. People had also been consulted on their opinions of the service through surveys.

Inadequate

Is the service responsive?

Our findings

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

This was the first inspection of this service under the new provider. At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people's needs were not met.

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's social needs were not met. For example, for a person who was diagnosed with mental health needs it was recorded in their care plan for staff to, 'sit with them and encourage [them] to have a chat with you or [they] would be socially isolated'. However, this person was left in the corner of the dining room without social interaction for prolonged periods other than to be supported with medicines, food, or drinks. Two staff members disclosed concerns about this person's welfare and felt they were neglected.
- People were not supported to take part in personalised activities regularly and this failed to meet their social needs. There was not an allocated activities staff member, and this reduced activities available to people. Staffing levels meant staff were restricted in providing activities due to time taken to support people with care and people remained in communal areas for prolonged periods without social stimulation other than a television. A person told us, "We used to do things, but we don't now." Another person who remained in a communal area without stimulation told us of their low mood living at the service.
- There was a focus on completing tasks at the service rather than person-centred care. For example, a staff member disclosed people were being supported out of bed early in the morning by night staff to avoid undue pressure on the morning shift staff and this was not people's preference. Behaviour charts evidenced 2 people had shown negative emotional reactions toward staff when being supported out of bed at times as early as 6am. Another behaviour record from early in the morning showed a lack of a personalised approach, where a staff member had 'told' a person they were to go to the lounge area.
- Most staff had not received appropriate training to support responsive care. Staff had not completed diversity and equality training. Less than half of staff had completed training in person-centred care.

The provider failed to ensure care and treatment was appropriate, met people's needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us that an increase in staffing for the morning shift would take pressure off them when supporting people out of bed.
- The provider told us they planned to have an allocated staff member for activities moving forwards.
- People were supported to maintain contact with relatives. Relatives visited the service freely and supported people to access the community.

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.

● People's communication needs were recorded in people's care plans, however, this was not always up to date. For example, a staff member told us a person did not always communicate well as they were not always lucid. This was not consistent with their care plan which stated they communicated well.
● Staff communicated with people in line with their needs and the Accessible Information Standard.

Improving care quality in response to complaints or concerns
● The provider did not have effective systems and processes in place for identifying, receiving, recording, handling and responding to complaints.
● The registered manager had not recorded any complaints or concerns. However, a relative told us they had raised concerns with the registered manager and actions were taken. The registered manager had not followed the provider's complaints policy. The registered manager told us they would ensure future concerns were recorded.

End of life care and support
● At the time of the inspection, there was no one receiving end of life care. The registered manager told us they had supported people at the end of their lives previously.
● Less than half of staff were recorded as having completed end of life training.
● People had advanced decisions recorded in their care plans, such as do not attempt resuscitation instructions and ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms. The ReSPECT process enables people to record their choices for care for any future emergency in which they are unable to make or express 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.

This was the first inspection of this service under the new provider. At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider failed to ensure its systems and processes were in place and effective. There was no accident and incident or behaviour chart audits in place. This meant the provider did not have the systems to identify themes and trends to inform them how to improve support and safety for people. The medicines audit was not effective and failed to identify concerns about the safe management of topical creams and 'as needed' medicines. There were no provider audits of care and this left the service without effective oversight, leaving people at risk of unmet needs.
- The provider did not have systems in place to effectively assess risk. The provider failed to identify where risk assessments were not in place. Care plan reviews were ineffective as these failed to identify and rectify the lack of risk assessments or information staff required to provide care. People were at risk of not receiving personalised care and safe support.
- There was no system in place to calculate safe staffing levels. The staffing levels at the service were not based on people's needs or the support needed in the event of an emergency and did not adequately mitigate risk at the service. This meant people experienced falls thorough lack of supervision, being asked to get up in the early hours of the morning and social isolation.
- The provider failed to ensure their own policies and procedures were followed. For example, there was a failure to follow the training policy which outlined that staff should receive relevant training to be competent in their roles. People were at risk of receiving care from staff that did not understand how to safely manage their care and meet their needs.
- The provider failed to have systems to ensure the upkeep and cleanliness of the building. This had led to the deterioration of walls, floors and soft furnishings which had become an infection control risk.
- The provider failed to ensure accurate and complete records were kept. For example, the registered manager did not keep a record of Deprivation of Liberty Safeguards authorisations, or complaints. This meant there was no provider oversight of these processes. Care records, including daily care notes and behaviour charts, did not have specific and relevant information and did not always outline what time care interventions occurred. This meant they could not be to accurately review for themes and trends to make the improvements made where required.

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; Engaging and involving people using the service, the

public and staff, fully considering their equality characteristics
● Contact with relatives was not always recorded. Incident records, such as falls records, did not consistently include information about whether relatives had been contacted about the incident and any subsequent actions. It was therefore not clear if the duty of candour was being followed.
● People and relatives had completed questionnaires giving feedback on the service. While some of this feedback was positive, some concerns had not been addressed. Responses from people had highlighted concerns over 3 months before this inspection about decoration, the upkeep of the garden, people wanting to go on outings and staff not always being responsive or well mannered. These were concerns which were still present at this inspection and the provider had not acted to resolve them effectively.

Working in partnership with others
● Although there was some evidence of partnership working, systems in place had failed to ensure professional input was sourced in a timely manner to improve outcomes for people. People who were at high risk of falls had not had referrals made on their behalf to support risk mitigation. An advocate had not been contacted to support care reviews for a person and this risked their support not reflecting their preferences.
● The registered manager told us they had not been confident in asking for support from external agencies, such as the local authority, where it had been needed.

The provider's systems and processes failed to assess, monitor and improve the quality and safety of the service provided. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and registered manager were candid during the inspection and completed relevant action plans in response to the concerns raised by inspectors. The registered manager took action to make relevant referrals where concerns had been highlighted by inspectors.
● The provider told us they would source a dependency tool to help inform future staffing levels.
● Relatives told us they felt the service was person-centred and people achieved good outcomes. A relative told us, "[The service] feels so homely, there is person-centred care, not a one size fits all approach. [My relative] likes to help with folding up towels. Residents have even been allowed to have a few strokes with painting the walls which brings back memories for them."
●Relatives and staff said the registered manager was supportive and approachable.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and support was appropriate, met people's needs and reflected their preferences.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people's health and safety were mitigated.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were protected from the risk of abuse.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were effective in achieving regulatory compliance.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed.

The enforcement action we took:

We served a warning notice.