HC-One Limited

Maple Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Maple Court Nursing Home is a care home providing personal and nursing care to up to 80 people. At the time of the inspection there were 58 people living there. There are three separate units accommodating people with differing needs. The home supported younger and older people, some of the people were living with dementia and/or physical disabilities.

People's experience of using this service and what we found
People did not always feel safe in the home. People were not always protected from the risk of cross infection. Risks to people's health and well-being were not always adequately assessed and planned for. People were sometimes supported with moving and handling in an unsafe way. Lessons were not always learned when things went wrong. Medicines were not always managed safely. There were not always enough staff and staff did not always have the training and knowledge to support people effectively.

People had access to other health professionals, however advice was not always followed in a timely manner. People were being restricted and this had not always been taken into consideration. There was poor oversight in relation to applications to deprive people of their liberty.

People were not always well-treated. People sometimes had to wait for support and staff did not always know people well. People were not always listened to and not always treated with respect.

The provider had consistently failed to make improvements that were effective or sustained. Systems to monitor the safety and quality of care were ineffective and did not always identify areas for improvement. Incidents we should have been notified of were not always sent to us. Systems in place were not always effective at sharing important information.

The environment was adapted so it was suitable for the people living there. People were supported to have enough food and drink of their choice. Staff were recruited safely.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 5 June 2019). The service has deteriorated to inadequate. This service has been rated less than good for the last three consecutive inspections. This will be the fourth consecutive time the provider has failed to achieve a good rating overall.

Why we inspected
We had concerns in relation to some safeguarding concerns that were being looked into and some complaints that were reported to us. As a result, we undertook a focused inspection to review the key questions of safe and well-led. Due to concerns we found during the inspection we expanded the inspection

to also include the effective and caring key questions.

The ratings from the previous comprehensive inspection for the responsive key question was used in calculating the overall rating at this inspection.

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

Enforcement
We have identified multiple breaches of regulation in relation to the safe care and treatment of people, safeguarding people from abuse, the monitoring and sustainability of quality and safety at this home, staff training, staffing levels and notifying the CQC of particular incidents.

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.

You can see what action we took at the back of this report.

Follow up
We will request an action plan for 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 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? 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 caring. Details are in our caring findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Maple Court Nursing 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 following concerns being raised by the local authority. 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.

Inspection team
The inspection was carried out by two inspectors and one assistant inspector. An Expert by Experience made telephone calls to relatives after the inspection. 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
Maple Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home did not have a permanent manager registered with the Care Quality Commission. The previous manager had failed to apply to de-register with us, so they remained registered, but they had not worked at the service for some months. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The local authority made us aware of some safeguarding referrals they had but did not share any concerns with us. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account

when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service. We were unable to speak with relatives on the day of our visit as the care home was not accepting visitors due to the pandemic. We spoke with 14 members of staff including nurses (including agency nurses), nursing assistants, carers, domestic staff, kitchen staff and the maintenance staff. In addition to this, we also spoke with the acting manager, deputy manager, area quality director and the area director from the provider. We made observations in communal areas to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 16 people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including audits and accident and incident records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures, training records, building safety records and quality assurance records.

We also spoke with six relatives over the phone to gain their views as we were unable to speak with them during our site visit.

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 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

- Risks were not always accurately assessed and planned for and lessons were not always learned. Information in care plans and risk assessments did not always match people's needs.
- Some people did not always feel safe when being supported with their mobility. One person said, "It's the odd times like this morning when I nearly fell. I had two agency staff and they don't know what they're doing." The person went on to say, "That makes me feel unsafe it shouldn't be allowed."
- We observed multiple examples of poor moving and handling. One person was supported to stand from the floor using an underarm lift on multiple occasions. Another person was also being supported to reposition in their chair using an underarm lift. This can cause injury to the person or to the staff members and is not safe.
- One person was deemed as not being a falls risk, however we observed and had been told the person tried to get out of their chair on occasions. If they attempted to get out of their chair, they would be at risk of falling but this risk had not been identified. One person told us the other person frequently tried to get out of their chair, but this had not been incorporated into their plan so lessons had not been learned.
- One person had a dressing on a wound, however staff were unaware of the wound and there was no plan in place to guide staff how the person should be supported with this. The dressing was partially saturated. This meant there was a risk the wound could worsen if not treated properly, would not be monitored and dressed appropriately.
- Staff were not always aware of people's needs. Staff were being moved around in the home so they could get to know people in other units. However, there were not always enough experienced staff in each unit to enable other staff to get to know people. There was also agency staff use, who also relied on experienced staff knowledge which was not always available. Staff told us they had never had time to read people's care plans.
- Therefore, people may be at increased risk in relation to their support needs, such as at risk of choking or their mobility, as staff may not always have enough information.

Preventing and controlling infection

- People were not always protected from cross contamination. Due to the COVID-19 pandemic, extra measures were in place to keep people safe, however the application of these measures was not consistent.
- Some areas of the home were dirty, such as paper towel dispensers, a laundry basket, radiators and doors. There was no soap in two bathrooms so people would have not been able to effectively wash their hands after using the toilet, and handwashing is important in reducing the spread of infection.
- Small coffee tables were being used by multiple people, however these were not cleaned between uses and food was placed directly onto the table, with no plates being used. This was unhygienic.

● Staff were applying the use of PPE differently between units. Some staff would wear gloves whilst supporting people to eat, but others would not which was not in line with guidance. Some staff wore aprons whilst interacting and in close contact with people, whereas other did not. Again, this was not in line with guidance.
● There were minimal social distancing measures in place. In the unit for those living with dementia, the dining had not been spaced out, so people were sitting directly next to and opposite one another. There was no evidence of staggered mealtimes or serving people in different areas of the unit to ensure social distancing could be followed. The communal lounge area was larger and whilst some chairs were well spaced, some were crowed together and, again, people were not socially distancing.
● Staff were not keeping apart, where possible. For example, staff would go between units to get more cutlery or food, but PPE was not changed between units and items were not cleaned to decontaminate them. As staff were based on separate units, they should work separately where possible to reduce the risk of spreading infection between units (called staff cohorting). However, the provider had not ensured staff were following this guidance.
● The units for those living with dementia had items in the corridors such as handbags for use by people and a clothing display. However, they posed an infection control risk if multiple people were to touch them and they were not cleaned in-between uses. There was no system in place to ensure this was monitored and no records to show they had been cleaned.

Using medicines safely
● Medicines were not always managed safely. Whilst we found stock levels generally matched, we found guidance about medicines was not consistently available.
● For example, two people received medicines covertly. One person had the guidance in place. However, the other person did not have guidance in place about how the medicines should be given covertly. One record stated one specific medicine could be 'mixed in a drink' however not whether the drink could be hot or cold, and the other medicines had no guidance. Staff told us they may put it in drinks or porridge at breakfast or main meals. However, some medicine can be less effective if it is mixed with hot food or drink and this had not been checked. Therefore, there was a risk the person may not always receive effective medicine.
● People who had 'when required' medicines did not always have protocols in place to help staff identify when they may need their medicines. This was in place for some, but not for others. For example, one person needed medicine if they were agitated however, there was no guidance as to when they may require a second dose of this. The acting manager explained a new medication system had been introduced and they were in the process of getting extra training for this.
● Guidance for staff regarding the application of topical creams was not always readily available, so staff were not always aware how or where topical medicine needed to be applied.

The above concerns constitute a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored appropriately; the medicines room and fridge were within the safe temperature range and this was checked regularly.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from abuse.
● One person told us of a safeguarding incident which they had reported to two staff members. Action had not been taken to protect the person and this had not been reported to the local safeguarding authority.
● We were told by staff of a safeguarding incident which had also not been documented or reported. We also observed a safeguarding incident on one day of our inspection, which staff did not report appropriately

and this was not recorded. This meant immediate action had not been taken to review these incidents and ensure all possible actions had been taken to protect people.
● Multiple staff told us they did not feel able to report concerns and they did not have confidence their concerns would be dealt with. One staff member said, "I do not know how to raise a safeguarding."
● We had to report some safeguarding incidents as we were not confident these had been recognised by the provider.

The above concerns constitute a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not always enough staff in the home and staff were not always effectively deployed. Feedback from people and staff confirmed this.
● There were three units in the home. People had to wait for support and had to wait to get up in the morning as there were not enough staff to get people up.
● One person told us, "You have to wait so long. Up to an hour I can wait… It isn't the staff; they are good carers. It's just there aren't enough." Another person commented, "You don't see them [staff] very often. There's not enough staff. You have to wait. I never time it but it feels like a long time."
● Staff also told us there was not always enough staff to support people safely. One staff member said, "Day staff are rushed. So people have to wait and sometimes they aren't up in time for breakfast. So, they have to eat in bed and it's not the same, they aren't as comfy so they don't eat well and it impacts on them."
● In the residential unit downstairs, many people chose to spend time in their rooms and others were in the communal area. Multiple people needed two staff to support them due to their needs. This meant the communal area was often left unattended whilst staff were supporting people in their rooms. This left people at risk.
● For example, one person used a chair to mobilise around the home, they were attempting to get out of this chair and no staff were present to support them. When a staff member did enter the communal area and saw this, the inspector had to assist them to get support for the person.

The above concerns constitute a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Checks were made on staff members suitability, such as employment history, references and criminal convictions.

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 requires improvement. 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.

Staff support: induction, training, skills and experience

- Staff were not effectively trained to ensure people were always well supported.
- Staff had not always recognised when safeguarding incidents had occurred, so they had not always been reported and appropriate action not always taken. Therefore, safeguarding training was ineffective.
- We observed multiple examples of poor moving and handling on multiple occasions by staff, therefore moving and handling training had also not been effective.
- Regular staff were being moved around to work in different areas of the home than they were used to and there was a reliance on agency staff, both carers and nurses. Agency staff would work with regular staff, however this meant staff did not always have the relevant experience of people's needs as they were supporting people they did not know.

The above concerns constitute a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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).

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.

- People were being restricted and this had not always been considered or included in DoLS applications.

Therefore, the legal right to restrict people had not always been verified.
● We observed examples of people being restricted, without clear explanation or assessment of the appropriateness of this. For example, one person continually had a table pushed in front of them by staff, but the person kept pushing this away. Another person had their walking frame removed from being close by them so they would struggle to attempt to mobilise.
● There was poor oversight of DoLS applications so it was not fully known who had an application submitted, what the outcome was of an application (if there was an outcome) or whether there were any conditions if an application had been granted.
● One person had a condition on their DoLS about their medicines. This condition was not being met and the provider had failed to ensure the person was being protected in relation to their condition.

The above concerns constitute an additional breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had access to other health professionals, however there were not always effective plans in place to support people with their health needs and advice from professionals was not always acted on in a timely manner. Handovers were not always effective at ensuring important information was passed on.
● For example, one person had a wound. Staff were unaware of this wound, there was no monitoring of this wound and no plan in place to ensure it was cared for appropriately. This meant there was a risk this wound could fail to improve or worsen.
● A staff member told us about the handovers. They said, "The handover is difficult because of the amount of agency use, it makes me a bit nervous because things can be missed." One person had experienced some visible symptoms of becoming unwell. A visiting health professional was requested to check on the person, they offered advice on the action that needed to be taken and when the visiting health professional checked the following day, this had not been actioned.
● Some people had fallen in the home. The provider had a process in place for staff to follow to ensure people remained well after experiencing a fall, such as carrying out regular checks on people. These were not always completed so we could not be sure people were always being protected and their changing needs were assessed.
● One person had measures in place to support their safety whilst sitting in a chair. This had not been assessed for safety and had not been incorporated into their care plans. It was not clear whether the person's choice had been considered as we observed the person trying to remove the safety measures.

Adapting service, design, decoration to meet people's needs
● The environment was suitable for the people who used the service, however this was not always kept sufficiently clean.
● There were grab rails around the service to help people walk along corridors. Signage was present to help people orientate. Equipment was available for people to use, however this was not always fully clean for people.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the food and had a choice. We observed choices available for people and those who needed support with eating were given this. One person said, "It's good food, we get a choice. Tonight, there is soup. We get more than one choice." Another person commented about the food, "It's quite

nice."

● We observed people being supported in line with their dietary needs, such as soft food or thickened drinks. The details of this were included in people's care plans. However, this information was not easily accessible for staff.

● Staff relied on word of mouth from other staff members about people's needs, as they did not often access people's care plans. However, as staff were working on alternative units so were less knowledgeable about some people's needs and there were agency staff, there was a risk this may not be communicated effectively.

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; Respecting and promoting people's privacy, dignity and independence

- People were not always well supported and were not always treated with dignity and respect.
- People had to wait for support which was not caring and did not support their independence. One person said, "I've usually wet the bed by the time they [staff] come. It makes me feel horrible really, I've never been used to that kind of thing." Another person said, "I'm stuck in a wheelchair you know, and if I want help I have to wait a while."
- People were supported by staff who did not always know them well or know their needs. One person said, "They [agency staff] don't know me. When two agency [staff] come to me I refuse."
- Some regular staff were working in different parts of the home they were used to. However, there were not enough experienced staff to direct them and they were not given time to read people's care records to get to know people. There were also multiple agency staff who would not always know people's needs.
- One staff member said, "I've been here a [a period of time] but never seen a care plan. When I get five minutes, I am doing paperwork or watching someone. I usually go via what the nurse says [someone needs]." Another staff member said, "I never have chance to read the care plans." However, nursing staff were often agency so would not always know people's needs.
- We observed a staff member shouting across a communal area, asking a person if they needed the toilet. This was not dignified.
- We observed some instances when snacks, such as biscuits and malt loaf, were given to people directly onto uncleaned tables, rather than plates or serviettes, which was not dignified.
- Some people had to wait for support with personal care as there were not always enough towels available and deliveries of freshly laundered towels from the laundry could be delayed. We asked the provider about this and they said they had already identified this as an issue and had ordered more towels and linen to avoid future delays.

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

- People were not always supported to ensure their views were listened to and were not always involved in decisions about their care.
- One person had told staff of safeguarding concerns and staff did not report this or take action. This meant the person expressed their views but this was not listened to and they were continued to be exposed to potentially poor, uncaring support.
- We observed poor and uncaring examples of moving and handling whereby staff did not explain things to people or handled people without asking their permission first. This meant people were not always given

the option to make decisions about their care.

The above concerns constitute a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 requires improvement. 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 provider had failed to improve to ensure people consistently received safe, effective, good quality care for the last four consecutive inspections. People had been exposed to less-than-good care for a significant period of time. Quality assurance systems were not always effective at identifying improvements needed.
- The provider had failed to ensure staff were following guidance in place from the government in relation to infection control which could put people and staff at risk. There were significant failings in relation to infection control such as cleanliness in some areas of the home, use of PPE and cohorting of staff.
- The provider had procedures in place in response to the pandemic, including in relation to housekeeping and the cohorting of staff. However, the provider had failed to ensure these procedures were being followed as staff did not always remain in the unit they were assigned to work in, including care and domestic staff and PPE was not always changed between units.
- An infection control audit had not been recently carried out. One had been undertaken in September 2020. However, none had been undertaken since then to the date of our first visit in December 2020. We found concerns in relation to infection control which had not been identified or resolved until we raised them with the provider. This had left people at risk.
- Other systems were in place such as a 'Twice Daily Walk Round' and a 'Weekly Dignity in Dining Audit' and these had also failed to identify improvements needed in cleanliness, as some areas of the home were not clean.
- Medicines audits had failed to identify the omissions we had found such as a lack of appropriate guidance for staff. An audit undertaken had stated every PRN medicine had clear instructions on how and when to administer, but this was not the case.
- There was a 'resident of the day' system in place, so everyone had a review at least once a month. The reviews encompassed aspects of their support such as care, housekeeping and medicines. These checks had failed to ensure people always received safe and good quality care, due to the level of concerns we found.
- We asked the provider how the safety and quality of the care had diminished, and this had not been fully identified prior to our inspection. They said, "We were relying on documentation. We have had big learning from this. Improvements weren't quick enough."

Continuous learning and improving care

- The provider had failed to continuously learn and improve. The service had consistently been rated less-than-good and had failed to embed and sustain previous attempts to improve the quality of care people

received.
● The provider proactively shared their action plan they put into place following our feedback. However, there had been a consistent failure to make and sustain improvements after previous concerns so we could not be sure this would be effective.
● There was poor oversight of accidents and incidents to ensure there was learning from these.
● Action had not always been taken to reduce the risk of further incidents and to learn from these. For example, two people had experienced incidents in which sensors which should alert staff when a person was standing up or getting out of bed were either not switched on or not working. No action had been taken to check they were working again following the incidents and an inspector had to request this was done.
● When people had experienced a fall or been found on the floor, there was a process in place to check on people for 24 hours following an incident to ensure they suffered no ill effects (assuming they had not had to attend hospital due to a fall). These checks were not always recorded so we could not be sure staff were following the provider's process. The provider had failed to ensure these were being consistently completed as these had failed to be completed multiple times.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and staff were not always effectively engaged and involved in the support they received. People and staff were not always listened to.
● Staff were not complimentary of the management team. Staff told us they did not feel able to raise concerns and did not feel confident issues would be dealt with. Staff felt the management team did not respect them which did not create a positive culture in the home.
● One staff member said, "If they [management team] gave me a little more respect or thanked me, I would be happy. A little appreciation goes a long way. They don't even speak to you, not even a good morning." Staff commented the management team were not always approachable. Another staff member said, "The management are not approachable."
● The provider's systems were not effective at ensuring key information was shared. The home had regular 'flash meetings' to share information, handover records between shifts, daily notes per person and incident forms to record incidents. However, these systems had failed to ensure timely action was taken to support people safely.
● In one example, the safeguarding incident staff told us about when we visited on our second day of inspection had not been written down in anyone's daily records, was not on the handover and a flash meeting had not taken place the day after the incident. However, if different staff had been working the following day and this incident had not been written down anywhere, it could not have been discussed.
● In another example, we saw health professionals had visited and given advice how to support a person who was unwell. A staff member had recorded this in the handover, but this advice was not carried out and there was no oversight as to whether this was completed or not. The health professional had to request again that actions were carried out.

The above constitutes a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider is required to submit notifications about particular events in the home, such as allegations of abuse, serious injuries and if a person had had an authorisation to be deprived of their liberty. We found one person who had an authorisation agreed in September 2020 and this had not been notified to us.

The above constitutes a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● The interim manager was aware of their responsibilities about duty of candour. They explained to us, "If there is an incident where we can identify at fault, we write to the persons or family or representative to say sorry and what we have put in place." However, due to some incidents not being reported or dealt with appropriately, we could not be sure all incidents would be reported as necessary.
● The previous inspection rating was being displayed in the reception area and on the provider's website, as required.

Working in partnership with others
● The provider was willing to work in partnership with other organisations. However, some health professionals had offered advice to keep people safe and this had not always been followed.
● The provider was willing to engage with us following the inspection and proactively kept us up to date with the action they were taking or had planned to make improvements.
● The local safeguarding authority was supporting the service due to concerns raised and the provider was engaging in joint meetings.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

Imposing of conditions via Notice of Proposal

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 Risks to people were not always assessed and fully mitigated. People were not always protected from the risk of cross infection. People were not always supported appropriately with moving and handling. Risks to people were not always assessed and planned for. Medicines were not always managed safely.

The enforcement action we took:

Imposing of conditions via Notice of Proposal

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 Service users were not always protected from abuse and improper treatment.

The enforcement action we took:

Imposing of conditions via Notice of Proposal

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 Systems or processes had not been established and operated effectively to ensure safe and good quality care was being delivered. Risks were not

always mitigated and full contemporaneous records were not always kept.

The enforcement action we took:

Imposing of conditions via Notice of Proposal

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 There were not always sufficient numbers of suitably qualified, competent, skilled and experienced staff to support people effectively.

The enforcement action we took:

Imposing of conditions via Notice of Proposal