Norse Care (Services) Limited

Mountfield

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Mountfield is a residential care home providing personal care and accommodation to 21 people aged 65 and over at the time of the inspection. The service can support up to 46 people. Mountfield is a purpose-built care home specialising in support for people living with dementia. Accommodation is provided across two floors.

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

People had been put at risk of harm. Actions to assess and mitigate risks to people had not been taken, this included risks relating to people's care needs and the environment. Infection control risks had not been assessed and measures to reduce the risk of infection were not in place. This put people at an increased risk of infection. The premises were not being safely managed. Equipment and exits had not been adequately maintained or secured.

Full collaborative assessments of people's needs had not taken place. People's needs had not been thoroughly assessed and pre-admission processes were not robust. Staff did not always support people in line with best practice and guidance. This had contributed to a lack of person-centred care within the service. This included the care planning and support provided to meet individual needs, such as end of life care, cultural needs, and family contact.

Processes and systems in place did not promote a person-centred culture. Effective systems to ensure feedback was actively gathered and used to inform the evaluation and improvement of the service were not in place. Quality monitoring systems were in place but had failed to ensure standards of care and regulatory requirements were met. The registered manager did not have a good oversight of the service being provided and how people were being supported.

We have made two recommendations relating to systems and application of MCA and DoLS and the provider's responsibilities under duty of candour.

Safeguarding systems had not always operated effectively to ensure safeguarding concerns were identified or reported. Reflective learning from incidents was not taking place and incidents were not being used to drive improvement. Whilst most areas of medicines were being managed safely we found improvements were required in the administration of topical medicines.

Training was provided to staff, however from concerns identified throughout the service it was clear that this learning was not fully embedded. Whilst systems were in place to monitor people's nutrition and fluid intake these were not being used effectively to ensure people's intake was sufficient.

Individual interactions between staff and people in the service were kind and caring, but this was compromised by interactions that had become system based and task driven. People were not fully involved or supported to express their views about their care.

A complaints system was in place but this was not always operated effectively to capture complaints and ensure these were investigated thoroughly.

Following our inspection visit the provider took responsive action to address the most immediate and concerning risks.

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

Rating at last inspection: This service reopened in January 2020 and this is the first ratings inspection.

Why we inspected
The inspection was prompted in part due to concerns received about people's safety relating to pressure area care and incidents. A decision was made for us to inspect and examine those risks.

The inspection was also prompted in part by notification of a specific incident. Following which, a person using the service sustained a serious injury.

The information CQC received about the incident indicated concerns about the management of falls from height. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. 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.

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, the premises and equipment, person-centred care, and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan 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.

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 of 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 always effective.

Details are in our effective findings below.

Requires Improvement

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 always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Mountfield

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors. An assistant inspector and two inspectors assisted with telephone calls to relatives and staff following our inspection visits.

Service and service type
Mountfields is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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 visited the service on 14 October 2020. During our visit we carried out observations of the environment and the care provided. We spoke with two people using the service. We reviewed records relating to the maintenance and management of the premises, records and care plans relating to the care of four people in the service, and records relating to the management of medicines. We spoke briefly, in order to clarify information and findings, with the registered manager, a regional director, a team leader, an agency support worker, and a support worker. Verbal feedback relating to any immediate concerns identified was given to the registered manager and regional director at the end of the visit. Following the inspection visit on 14 October we requested the provider submit an action plan which we reviewed.

After the 14 October 2020 visit, we spoke via the telephone with 11 relatives regarding their experience of the care provided. We also spoke with eight staff members; this included, four support workers, a senior support worker, two team leaders, and a member of the domestic staff team.

A second inspection visit took place on 29 October 2020. The second visit was carried out to complete the inspection and check that the provider had taken steps to improve the safety and standard of care provided. During our visit we reviewed care records relating to the care of six people. We spoke with a further two people. We spoke with the registered manager, a strategic support manager, a team leader and a deputy manager, in order to clarify information and findings. Verbal feedback on any concerns identified was given to the registered manager, strategic support manager, regional director and the nominated individual at the end of this visit. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

A formal feedback meeting covering all areas of the inspection was carried out on the 11 November with the strategic support manager, regional director, the nominated individual, and chief operating officer.

After the inspection
The provider submitted weekly action plan updates which we reviewed.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly opened service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks had not always been identified which meant appropriate risk assessments had not been put in place. For example, For example, four people who were at high risk of pressure sores had either inaccurate skin integrity risk assessments or no skin integrity risk assessments in place.
- Where risks had been identified, actions had not always been taken to mitigate risks. For example, staff had not consistently taken measures to reduce the risk of pressure areas developing and actions in response to weight loss concerns had not always been taken.
- Environmental risks had not been sufficiently monitored and mitigated. This had put people at serious risk of harm. For example, regular required fire safety checks had not been carried out and staff were not confident on what measures to take in response to a fire. We found toiletries and a prescribed cream unsecured, ground floor windows leading out to the car park unsecured and a gate in a garden area leading to the back of the service and a public road was not locked.

Risks to people had not been fully assessed and actions not always taken to mitigate against the risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during the inspection. They confirmed actions in relation to environmental risks had been taken. They had commenced full reviews of potential risks to people and the management of these. On our second inspection visit we found improvements in relation to environmental risks but continued to have concerns regarding the assessment and management of risks related to people's care needs.

Preventing and controlling infection

- Risks relating to preventing and controlling infection were not sufficiently assessed. Individual covid-19 risk assessments were not in place. In addition, staff had not fully considered or understood how the risk of covid-19 transmission could be reduced. We found examples where staff had not acted in accordance with government guidance to reduce the risk of transmission.
- Infection control measures were not followed to ensure risks were minimised. Offensive waste was not disposed of in accordance with the provider's own infection control guidance. For example, we found multiple incidences where personal and protective equipment and offensive waste had been left un-bagged and left in bins around the service, including in people's bedrooms.
- The storage and disposal of clinical and offensive waste was not being managed. We found multiple instances where bins did not have liners and where bins were in use but full and requiring emptying, this included clinical and offensive waste bins.

● Staff were not adhering to infection control measures in relation to using sluice rooms which increased risk relating to infection control. On both visits to the service we checked one of the two sluice rooms, which we observed in frequent use. On both days we found improper practice. For example, moving and handling equipment had been stored in the sluice room, as well as towels and clothing. On our second visit, despite raising our concerns previously, we again found towels and clothing as well equipment for hair washing left on the sluice room floor.
Effective actions had not been taken to ensure infection control risks had been assessed, controlled or prevented. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection visit the provider responded to these concerns. They confirmed they had started to work with staff to improve their understanding and adherence to infection control policies and procedures, and new working bins had been ordered.

Systems and processes to safeguard people from the risk of abuse
● Whilst most safeguarding concerns had been identified and reported as required, we found instances which had not been. This meant we could not be confident safeguarding systems and processes were operating effectively. Following our visit we raised a safeguarding concern with the local authority.
● Staff had received training in adult safeguarding and information on how to raise safeguarding concerns was displayed in the service. However, not all staff spoken with demonstrated a good understanding of adult safeguarding and what they needed to report.

Learning lessons when things go wrong
● Whilst the provider had systems in place to analyse incidents for patterns or themes, this was not being used effectively within the service. The registered manager did not evidence a good understanding of issues and risks arising from incidents in the service. Falls that occurred in the service were recorded on a falls diary but there was no evidence that the registered manager reviewed these. The falls diaries being used did not evidence that collation or patterns were considered.
● Incidents were not used as learning points. Staff told us incidents were not routinely discussed and learning from them was not disseminated. One staff member said, "[We] don't really get time to discuss incidents, [we've] only had one team meeting."

Staffing and recruitment
● Systems were in place to assess the amount of staff required to meet people's needs. However, we received variable feedback from people, relatives, and staff on staffing levels. One person and a staff member told us that they felt there was not always enough staff in the mornings. The person we spoke with said they sometimes had to wait for help but this did not cause them a significant problem. Several relatives told us they felt staff appeared under pressure.
● The registered manager told us that the home had opened shortly before the covid-19 pandemic and this had impacted on recruitment. They told us staffing numbers had improved and the service was now better staffed. On the days of our inspection visits we observed plenty of staff in the service. We reviewed staff rotas which did not raise significant concerns regarding staffing levels.
● Processes had been followed, including appropriate character checks, to help ensure staff were recruited safely and potential risks identified.

Using medicines safely
●Improvements were required in the administration of prescribed topical creams. We found numerous instances where records relating to the administration of prescribed topical creams had not been

completed. In addition, instructions for their use on cream charts were not always clear. This meant we could not be confident these medicines were being used as prescribed.

● Other prescribed medicines were administered and managed as prescribed.

Requires Improvement

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 is the first inspection for this newly opened service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Whilst the design of the home had been thoughtfully undertaken in respect to the needs of people living with dementia, poor standards across the service had compromised this.
- Areas of the home were not always clean. For example, we found a bedroom room with a strong offensive smell, an unemptied bin, and faecal matter in the bathroom. Staff told us the room had been unoccupied for a month. Bins around the home were not being regularly emptied. The cleaning logs for the sluice showed gaps and we identified concerns relating to the cleanliness of this area. A member of the domestic staff told us the domestic team had only recently become fully staffed and there remained issues with differing standards amongst the team.
- Equipment and the premises had not been maintained as required. We observed a lift control panel loose with wires exposed, a piece of moving and handling equipment with an out of date service certificate, the boiler service was out of date, and a fire exit was restricted by overgrown shrubbery.
- The security of the premises had also been compromised. We identified open and unsecured ground floor windows that led out on to the car park, along with a steep slope and flight of stairs. A garden area had an unsecured garden gate which led round the back of the building and meant that public road could be accessed.
- Whilst bedroom door signs could be personalised to help people navigate to their bedroom the use of these was variable. We found people were using bedrooms which had signs on their doors that indicated the rooms were available and ready for new use. This was confusing and did not help orientate people to their rooms or show staff and visitors to the service if a room was occupied.

The premises and equipment were not clean, secure, properly maintained, or suitable for the purpose for which they were being used. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our return visit we found improvements to the security of the premises, although other concerns remained. The provider took immediate action to put in place the servicing required for the equipment and confirmed they would review other areas of concern.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Assessments of people's needs were variable in quality. We reviewed several pre-admission assessments

which did not contain enough information and had not been fully completed. Several staff also told us they felt they were not always provided with enough written information to support them in the provision of care. One staff member said, "When [we have] new admissions I do feel there needs to be more information relayed."

● It was not clear that pre-admission assessments were carried out in enough depth and with enough time to fully assess people's needs and ensure the service could meet them. For example, one person's preadmission assessment only contained information from the hospital they were being discharged from and there was no evidence the person's relatives, who had been supporting the person at home, had been consulted. This was confirmed when we spoke with the person's relative. Two further relatives also provided us with examples which demonstrated that not all information regarding people's needs and choices had been completed in advance.

● Care plans and assessments did not contain enough information on how to support people with all aspects of their health. For example, there was very limited, to no information, on how to support with oral health needs.

● Staff did not always support people in accordance with best practice guidance and current legislation. For example, in relation to wound management or health and safety requirements.

● Whilst we saw evidence of people accessing health care services it was not always clear if health concerns were being enough identified and acted on. We found examples where staff had queried people's concerns regarding aspects of people's health but had not been proactive in seeking advice and support from health care professionals.

The failure to carry out, collaboratively, assessments of people's needs and preferences with relevant persons was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Whilst staff had received training in a range of areas specific to people's needs it was not clear that this training had been fully embedded.

● Practices and issues identified throughout the service indicated further support was required to ensure staff fully understood areas such as infection control, adult safeguarding, pressure care, risk assessing, and care planning. Two relatives provided us with examples that suggested staff did not fully understand how to manage their episodes of distressed behaviour.

● Systems were in place to ensure staff received regular supervision. Competency checks were carried out and new staff received an induction prior to starting work in the service.

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.

● Most people's care records contained information on people's ability to make decisions. Whilst there was information on capacity to consent in areas such as accommodation and information sharing, there was limited information on specific areas relevant to individuals. For example, around diet or pressure care interventions.

● People's consent was sought in day to day support. Staff understood how to support people in decision making and the importance of this. However, their knowledge of the MCA was variable.

● Systems in place had not been effective in ensuring the need for DoLS applications had been identified in every case, or that applications were made in a timely manner. For example, we found one person had moved from a previous service where a DoLS had been applied for but there had been a significant delay in staff at Mountfield applying for a new DoLS as required.

We recommend the provider review its systems and application of MCA and DoLS in the service.

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

● Whilst systems were in place to monitor people's nutrition and fluid intake these were not being used effectively. For example, people coming in to the service were put on a three-day food chart to help identify concerns. However, these were not consistently filled out and analysed. Additionally, people on fluid charts did not have their intake totalled up which meant we were not confident issues arising from poor intake would be identified.

● People's individual requirements in relation to meals were catered for. People and relatives told us the food was of good quality. One relative said, "[Name has] been really really pleased with the food, [they] talk about it quite a bit." A person told us they had specific dietary requirements which were met. Meal times had a flexible ethos so people could eat when they choose. We observed some of the lunch time meal on one day and this appeared pleasant and organised.

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 is the first inspection for this newly opened service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- It was not always clear that systems within the service were caring. For example, several relatives gave examples where staff had not fully understood the emotional impact there was in their loved one moving in to a care home. This had meant interactions had been process driven and task focused.
- It was not always clear that staff knew people well, including their needs and social history. Staff told us information given to them did not always support this.
- There were individual caring interactions between staff and people in the service. A relative said, "Staff seem committed and lovely." We observed supportive interactions and staff were attentive to people if they were showing distress.

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

- People were not fully involved or supported to express their views about their care. Two people told us whilst staff were kind there was limited discussion about their care and their experience of living in the service.
- Regular formal reviews of people's care had not taken place. Relatives told us they did not always feel informed and updated. One relative said, "Nobody has picked up the phone to talk to me person to person just to advise me as to how things are going for [x] weeks or so." There were no other systems to support people to participate in decision making about their care such as resident meetings.

Respecting and promoting people's privacy, dignity and independence

- It was not clear how people's independence was being fully planned for and supported. For example, when people were isolated in their rooms due to infection control policies, there were no assessments in place on how this might impact on people's independence and what could be done in response.
- People's privacy and dignity was largely respected. Relatives told us staff supported their relatives to maintain their dignity. One relative said, "[Name has] been quite well turned out, their clothes looked clean and tidy on my last visit [name] really looked quite smart." We did, however observe one instance where staff could have been more attentive to one person's dignity.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly opened service. This key question has been rated requires improvement. This meant people's needs were not always met.

End of life care and support; 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

- The care provided had not always met people's individual needs. For example, in relation to pressure care or nutrition.
- There was no evidence people were supported to consider and plan for their needs at the end of their life. Staff told us no one in the service was receiving support at the end of their life. However, we reviewed one person's care records that showed they were end of life. Whilst discussions with the person's G.P had taken place and anticipatory medicines prescribed, staff had not identified the person required end of life support. As a result no end of life care planning had taken place.
- Care plans were of variable quality. The majority of those we reviewed did not contain enough or accurate enough information for staff to ensure they could provide person centred care. This was especially the case for people new to the service or staying for a short period of time. A staff member said, "Some of the care plans are helpful. The ones where they have just come in from hospital there is very little in the care plans for them."
- There was no evidence that people or their relatives had been consulted and involved in planning or reviewing their care. People and relatives we spoke with told us they had not been provided with this opportunity. One relative said, "They just need to up their game a bit about how they deal with family members." This compromised the service's ability to ensure person centred care was being delivered.
- Whilst we saw some activities and social interactions between staff and people, it was not clear how people's interests and cultural needs informed activities provided. A number of people's care plans showed they had strong religious beliefs but there was no detail on how staff would support people to fully engage in this. We spoke with one person who told us they had received little to no support in this area and missed talking with other people of the same faith.
- Staff had put in place socially distanced window visits for relatives. Two relatives told us that whilst arrangements had been well communicated the window visits did not work well as their relatives' individual needs around this had not been considered. They said there had been no discussion about how these were working or could be better facilitated. We found people did not have individual care plans or assessments around this type of contact.

People's care needs had not been met or planned for collaboratively. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

●Whilst a complaints system was in place it was not clear this was working effectively within the service. We were aware of some complaints that had been made to the registered manager which were not documented within the services complaints system.

● Where complaints had been documented aspects of some of the complaints had not been fully explored to help identify if there were genuine concerns and establish if improvements were required.

We recommend the provider review how staff are supported to ensure complaints are fully identified, investigated and the effectiveness of the complaints system.

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.

● People's communication needs were assessed however information regarding this was brief. For example, one person's communication needs were recorded as "lacks capacity".

● During day to day support staff did adapt how they communicated with people. For example, by using visual prompts to aid understanding. One staff member told us how the service had communication cards that could be used to support discussion 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.

This is the first inspection for this newly opened service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service was not promoting a person-centred culture. Principles of person centred care planning and support were not embedded within the service. Equality characteristics had not been fully considered, planned for, or supported.
- Care plans did not always reflect people's needs as information was confusing and not always accurate. This hindered the delivery of person-centred care.
- Processes to ensure people and relatives could provide feedback on their care were not in place. None of the relatives or people we spoke with had been asked their opinion about the care provided. Many of the people using the service had used it on a short term basis. The provider had failed to consider how feedback could be gathered from these people to improve the quality of the care provided.
- Systems to fully engage staff, and consider their equality characteristics had not been put in place. Staff told us only one team meeting had been held since the service opened and that issues within the service were not fully communicated or their views sought.

The provider had failed to put in place effective systems to ensure feedback was actively gathered and used to inform the evaluation and improvement of the service provided. Records were not always accurate or complete. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Whilst quality monitoring systems were in place they had failed to ensure standards of care and regulatory requirements were met. We identified numerous failings across the service that placed people at risk of harm. Where audits had identified issues we found timely and effective action had not been taken.
- Systems that were in place had failed to effectively assess and mitigate risk of harm. For example, in relation to pressure care, fluids, and nutrition. Staff also told us they had not been offered opportunities to participate in risk assessments in relation to equality characteristics and Covid-19.
- Effective communication was not taking place because systems were not being used properly. Staff told us the way in which shifts were organised and how handovers were completed meant they did not always receive the information required. A staff member said, "I do feel there could be more information handed over to us." Another staff member told us information such as hospital admissions was not always passed

on.
● Staff worked in distinct teams on designated shift patterns and as a result had little to do with staff on different teams. The provider had not considered how this might impact the culture of the home and on the care provided and how they could mitigate this. It was clear from talking to several staff that there was potential for this system to cause conflict.
● The registered manager did not have a clear overview of people's needs and was not proactively managing the service. Areas such as complaints or incidents did not evidence oversight of the registered manager. Relatives told us they had little contact with the registered manager. Two relatives had raised issue with telephone calls being returned. Staff told us they felt the registered manager was under pressure. This meant there was a danger staff would not feel able to engage and approach the registered manger.

Quality monitoring systems were ineffective in monitoring and improving the quality of the service. The systems in place had failed to identify, monitor and mitigate concerns within the service which placed people at risk of harm. This meant the service was in breach of Regulation 17 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
● Prior to the inspection we received information which raised concerns regarding the provider's adherence to its duty of candour responsibilities. The provider's approach was discussed with the registered manager and regional director.
● The way in which some complaints had been responded to did not fully evidence that staff understood their responsibilities under duty of candour.

We recommend the provider reviews its responsibilities under duty of candour.

Continuous learning and improving care; Working in partnership with others
● Following the concerns raised at our inspection the provider responded promptly to address the most immediate and pressing concerns.
● The provider undertook reflective action to establish factors that had contributed to the failings in the service. They identified that opening shortly before the covid-19 pandemic along with a high turnover of people staying at the service had impacted on the service in a range of areas. The provider told us they planned to put a hold on admissions whilst they reviewed and amended the vision and strategy the service and admissions.
● Following our inspection visits the provider took proactive action to engage with other stakeholders to help make improvements in the service.

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 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: The care provided did not meet people's needs. Collaborative assessments with people and relevant persons had not been carried out. Relevant persons had not been supported to make or participate in making decisions about the care and treatment provided or in the manner the regulated care is carried out. Care plans did not consider how people's support would be carried out in order to meet their needs. Regulation 9 (1)(a)(b)(c) (3)(a)(b)(d)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment How the regulation was not being met: The provider had failed to ensure premises and equipment were clean, secure, and properly maintained. Regulation 15 1(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Quality monitoring systems were ineffective in monitoring and improving the quality of the service. The service had failed to

identify,monitor and mitigate concerns within the service which placed people at risk of harm. Records were not accurate or complete. Feedback had not been sought to enable the provider to evaluate the service provided. The provider had failed to evaluate and act on concerns.

Regulation 17 (1) (2)(a)(b)(c)(e)(f)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: People were placed at risk of harm because risks were not assessed and actions to mitigate risks were not taken. Actions had not been taken to ensure the premises were safe for their intended purpose. The provider had not ensured staff had the skills and competence to provide care safely. Staff had failed to ensure the risks of infection were assessed, prevented, and controlled. Regulation 12 (1) (2)(a)(b)(c)(d)(h)

The enforcement action we took:

A warning notice was issued to the provider in relation to the assessment, prevention, and control of thr spread of infections.