Fidelity Healthcare Limited

# Marlborough Lodge

## 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 well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Marlborough Lodge provides accommodation and personal care for up to 18 people. The service provides support to adults who are over and under 65 years, people living with dementia and mental health conditions, people who have a physical disability and people with sensory impairment. At the time of our inspection there were 17 people living at the service.

Accommodation is provided in one adapted building over two floors. People had their own room and there was a communal lounge, a dining area and communal bathroom facilities. People could access a garden from the ground floor.

People's experience of using this service and what we found
The provider failed to make sure risks were consistently identified and assessed. This meant the provider could not demonstrate management plans were in place to mitigate risks and keep people safe. Where risks had been identified, management plans lacked details and were not personalised. Monitoring evidence for the risks identified such as food and fluid monitoring did not demonstrate actions were being taken when needed.

The provider failed to ensure behaviour support plans were detailed and personalised. For example, plans we reviewed gave guidance for staff to 'monitor' or to 'reassure', but it was not clear what this meant and how it would support the person.

Incidents and accidents were not robustly reviewed. This meant the provider could not demonstrate action they had taken to prevent reoccurrence. Where action was recorded in response to risk, the provider could not provide evidence the action had been completed. This placed people at risk of avoidable harm.

The provider failed to ensure there was sufficient guidance for staff in relation to people's health conditions. People had sustained unexplained injuries which were being treated by community nursing teams. However, there were no details in people's care records about the wound or the treatment being provided. This meant staff did not have guidance about what to do if they were concerned about the injuries or dressings in between nurses visiting.

The provider failed to ensure medicines were managed safely. People prescribed 'as required' medicines did not always have a protocol in place. Medicines did not have dates recorded when they were opened which increased risks of staff using expired medicines. Staff were not recording required temperatures of all medicine's storage.

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 this practice.

The provider used CCTV in communal areas around the service. They were not able to provide us with evidence they were registered with the Information Commissioner's Office. There was also no evidence in people's records they had consented to being filmed.

The provider failed to ensure safeguarding incidents were consistently reported to the Local Authority Safeguarding Team. There was an additional failure to ensure notifiable events were reported to CQC through statutory notifications.

Staff were observed using unsafe moving and handling techniques during our inspection. This placed people at risk of avoidable harm. Training for moving and handling was not carried out by a person who had skills, knowledge and competence to instruct others. Staff had not received a comprehensive induction and had not been given training about how to evacuate the service in the event of an emergency. We observed staff treating people in a way that was not person-centred or responsive to their needs.

The provider failed to implement effective quality monitoring systems. Audits carried out had not identified concerns we found, and some did not cover areas of poor practice. This meant the provider was not identifying issues so they could make the necessary improvements. The provider carried out improvements when given feedback by CQC but should not rely on inspections for quality checks.

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 12 April 2022) and there were 2 breaches of regulation 12 and 17. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 11 February 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective and Well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

Enforcement
We have identified breaches in relation to safe care and treatment, need for consent, staffing 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
Following our site visit we met with the provider to seek assurances about what action they were going to take following our visit. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service effective?**

Inadequate

The service was not effective.

Details are in our effective findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# Marlborough Lodge

**Detailed findings**

## Background to this inspection

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

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

Inspection team
This inspection was carried out by 2 inspectors.

Service and service type
Marlborough Lodge 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. Marlborough Lodge 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 not a registered manager in post. A new manager was employed and planning to register with CQC.

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 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 used all this information to plan our inspection.

During the inspection
We spoke with 4 people about their experiences of care received. We also spoke with 4 relatives on the telephone. We spoke with 4 members of staff, the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed 11 people's care and support records, multiple medicines records, health and safety records, quality monitoring information, accidents and incidents, staff meeting records, staff training records, 3 files for staff recruitment. Safeguarding logs, complaints records and fire safety records.

Inadequate

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
At our last inspection the provider had failed to make sure the service was clean and did not reduce the risk of the spread of infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12
● The provider could not be assured they were doing all that was reasonably practicable to prevent the spread of infection. For example, staff were seen to have nail varnish applied to nails and were wearing rings with stones. This type of ring can carry bacteria and cause cross contamination.
● At the last inspection some areas of the service were not clean. At this inspection we found there had been improvement, but further improvement was needed. The provider was not promoting safety through the layout and hygiene practices of the premises. We found some areas of the kitchen were not clean. The provider took action during the inspection to clean the oven. However, this action had not been identified by the provider without CQC prompting them.
● At the last inspection there were not cleaning schedules in place to record when touchpoints or soft furnishings were cleaned. Cleaning of touchpoints had still not been added to cleaning schedules. This meant the provider could not be assured this cleaning had been carried out.

Failing to have systems in place to reduce the spread of infection was a continued breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection, we found PPE was not being stored safely. At this inspection we found this had improved and PPE was stored in cupboards around the service. We were assured that the provider was using PPE effectively and safely.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The provider failed to ensure risks to people's safety were robustly assessed and managed. This placed people at increased risk of avoidable harm.
● For example, some people were unable to use call bells to indicate they needed assistance and emergency support. The provider had failed to identify and mitigate this risk. This meant some people stayed in their rooms all day and their safety and well-being were not being monitored.
● People with diabetes did not have any guidance in their plans for staff to know how to provide safe care and support. This included action to take if the person became unwell or showed signs of ill health.
● People who experienced distress reactions did not have detailed or personalised guidance in place for

staff to follow. Guidance recorded asked staff to 'monitor' with no further details. Behaviour monitoring plans in place did not record potential causes of distress or action taken during and following distress. This meant the provider was not able to evidence how they evaluated incidents to support people safely.

● There was no guidance in place to record what wounds people had or what staff should do when there were issues with wound dressings. For example, people who had wounds and received treatment from the community nursing team had no information in their records for staff to know what to do if there was an issue with wound dressings. We were told by professionals that there were concerns staff had not responded to issues with wound dressings safely. This had placed people at increased risk of avoidable harm.

● People at risk of developing pressure ulcers had risk assessments in place but there was no guidance on what actions were needed when people were assessed as high risk. People with specialist mattresses in place did not have guidance on inflation rates. Mattress checks were not being carried out to monitor they were inflated correctly. This placed people at increased and avoidable risk of further skin deterioration.

● People at risk of malnutrition and dehydration did not have clear guidance in place for staff to support people safely. People who had been identified as not drinking enough did not have fluid monitoring in place. People who were losing weight did not have guidance in place for staff to know how to support them.

● Not all incidents had been recorded and reviewed by management robustly. Where reviews had been carried out it was not clear of action taken to prevent reoccurrence.

● For example, the day before our site visit, one person had fallen out of bed. This had been reviewed and management had recorded 'all safety measures in place'. We found this person hanging out of bed and had to get staff to help them as they were at risk of falling out of bed again. We did not see what the safety measures were to prevent reoccurrence. A sensor mat was on the floor one step away from the bed. This would not prevent the person falling from the bed.

● For another person with dementia we found they had left the building unescorted on three occasions. One occasion was during the night. Whilst the provider told us they had taken disciplinary action against staff on duty, this person had no risk assessment for leaving the building unescorted. The provider had also not carried out any further mitigation of risk such as out of hours checks to monitor staff.

Failing to assess and mitigate risks for people placed them at risk of avoidable harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● At the last inspection we found records for medicines incidents did not demonstrate errors had been investigated. At this inspection we found one discrepancy for medicines stock that had not been reported to the management. This meant no investigation had taken place and the provider was not able to tell us what had happened. The provider later informed us this was a counting error. However, staff administering medicines since the error had not reported this concern and continued to record the incorrect amount of stock.

● Medicines were not managed safely. People who had 'as required' medicines in place did not have 'as required' protocols in place. Staff did not have guidance on how to administer this type of medicine which meant people were at risk of not having their medicines as needed. We observed one person tell staff they were in pain, they also looked like they were in pain. Staff did not respond to this request and we found they had not received their 'as required' pain relief that day.

● Where medicines were handwritten by staff there was no staff signatures to demonstrate a check on the prescribing instruction had been made by 2 members of staff. This check helps to reduce the risk of medicines errors.

● We found topical creams and one bottle of medicine that had not been dated when opened. This meant the provider could not be assured they would not be used after expiry dates. Some medicines are not as

effective if used after expiry dates.
● Staff were not recording minimum and maximum fridge temperatures. Records seen had one temperature recorded when the staff checked it. We raised this with the provider during our inspection who did not know this check was required. Medicines requiring cold storage may not be safe to use if they have been stored outside of a safe temperature range.

Failing to manage medicines safely at all times placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff had not been provided with sufficient training to demonstrate competence in moving and handling people. During our inspection, we observed staff using unsafe moving and handling techniques. We informed the provider on the day of the inspection.
● Moving and handling training had been provided online and with senior staff assessing skills. However, none of the senior staff had received additional training to be safe to instruct others in moving and handling techniques. This meant the provider could not be assured staff were being shown safe techniques.
● Staff had not been provided with training to ensure they had the skills and knowledge to keep people safe in an emergency. For example, records we reviewed showed staff had not received training about how to evacuate people in the event of a fire or how to administer first aid. The provider told us they had not carried out evacuation drills and were not able to provide evidence of these taking place. The provider's first aid risk assessment failed to identify the type of first aid training needed to keep people safe.

Failing to make sure staff had the competence and skills to support people safely placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been recruited safely following the provider completing necessary pre-employment checks.

Systems and processes to safeguard people from the risk of abuse
● Systems were not in place or effective to safeguard people from the risks of abuse. Incidents of safeguarding had not always been reported to the local authority safeguarding team. This meant actions to keep people safe had not been reviewed by local teams. We shared incidents we found during the inspection with the local authority safeguarding team.
● Examples of incidents not reported included, unexplained bruising and one head injury which placed people at risk of further harm.
● The provider had not investigated all incidents to determine causes and review measures to keep people safe. For example, one person had sustained bruising to their eye. We were not able to see an incident report, any investigation or action taken in response to this unexplained bruising.
● We observed staff treating people in ways that disregarded their needs. One person asked staff for a cup of tea as they were thirsty. Staff responded by telling the person it would soon be lunch time and did not give the person a cup of tea as requested. Another person was sat in a chair with their walking frame next to them. Staff wanted to move the frame, but the person said no. Staff prised the person's fingers off the frame and moved it anyway.

Failing to make people were safeguarded from abuse and improper treatment placed people at risk of avoidable harm. This was 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.

● Despite the shortfalls we found during the inspection, people and relatives told us they thought people were safe at the service. Comments included, "Where [relative] is, they are happy, settled, safe and secure" and, "Yes [relative] is safe, I have no concerns or worries, they phone me with any little thing."

Visiting in care homes

● At our last inspection the registered manager had misinterpreted guidance about visiting in care homes which meant visiting was not permitted during an outbreak of COVID-19. At this inspection this had improved.

● People could have visitors without restriction. Relatives we spoke with all told us they could visit regularly and were made to feel welcome by staff.

● The provider was continuing to ask visitors to complete a Lateral Flow Test (LFT) for COVID-19 prior to entry into the service. This was not current government guidance but relatives we spoke with told us they did not mind doing this if it helped to keep people safe.

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 our last inspection we rated this key question requires improvement. 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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not working within the principles of the MCA. For example, when staff administered medicines covertly, there was no documented evidence to demonstrate the decision-making process. This meant the provider could not demonstrate who had been involved in the decision and that the decision was the least restrictive.
- One person who had an authorised DoLS in place had conditions relating to their authorisation. The provider was not able to demonstrate they had met this condition for the person.
- During our inspection we received concerns about the provider making 'blanket decisions' for people. We were told the provider was not allowing anyone to leave the home and asking relatives to apply for permission to take people out of the home. We spoke to the provider about this who confirmed he authorised any requests to take people out. This was not supporting people's best interest around specific decision making.
- The provider had CCTV in place in all communal areas. There was no evidence in people's records of their consent to being filmed.

Failing to work in people's best interest and within the legal framework of the MCA placed people at risk of harm. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider took action during the inspection to put MCA assessments and best interest decision making in place for covert medicines. However, they still had not carried out a check with the GP about how medicines were to be administered safely.

Staff support: induction, training, skills and experience

● At our last inspection we recommended that the provider seek advice to make sure their induction for new staff met the industry standard. This was because the provider was not using the Care Certificate for their induction of new care staff. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● At this inspection we found this had not improved as the providers induction was not robust. Staff could complete the Care Certificate knowledge in their eLearning. However, the provider was not able to demonstrate staff had been assessed for competence. This meant the provider could not be assured staff were competent to be left to work alone.

● We saw examples of poor practice which demonstrated staff lacked competence. For example, staff left cupboards open when they should be kept locked at all times. We found a chair was blocking a fire exit and were told staff had moved it and left it in this position.

● The provider told us their induction was robust and all new staff had monthly supervisions which included competence assessments for 6 months. They were not able to provide us evidence of any of this.

Failing to make sure staff had the support, training and supervision to enable them to carry out their role placed people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At our last comprehensive inspection, we found people needing support to eat experienced a delay in receiving their meal. We also found care staff were having to prepare evening meals which led to staff feeling there was not enough staff in the evenings. At this inspection, we found there had been some improvements, but further improvement was required.

● During an observation of mealtime, we observed staff placing clothes protectors on people without asking people if they wanted to wear them. This included placing a clothes protector on a person who was sleeping.

● We observed one person experienced a delay in receiving their meal. The person was sat at the dining table and waved their knife and fork at staff. Staff did not respond to this person or give them their meal in a timely way.

● One person told staff they did not want to go to the dining room for lunch, but staff helped the person to stand and moved them anyways. This was not the person's wishes.

Failing to provide care that was person-centred and in line with people's wishes and preferences placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Food looked appetising and people and relatives told us the food was a good standard. One relative said, "The food is amazing, [relative] eats well and is well fed."

● The provider had instructed the cook to work evening shifts to support mealtimes. This meant care staff did not have to leave their caring role to prepare meals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

● Staff worked with the local GP surgery and had a weekly visit from an advanced practitioner. There was evidence in people's notes that any injuries were reported to the GP.

● People with specific health conditions did not always have guidance in place for staff to know what effective support to provide. We have reported on this in more detail in the key question safe. This included conditions such as diabetes.

● Staff had handovers to share information about changes in people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed prior to admission by the provider. These assessments were carried out by senior staff.

● The provider used tools to assess people's needs such as the Waterlow assessment tool for assessing risk of developing pressure ulcers. We found they were not using this tool safely and have reported on this in the key question safe.

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

● People had their own rooms and use of bathroom facilities. People were able to personalise their rooms if they wished.

● Communal rooms were available and there was a small garden to the rear of the property. This was accessed from the ground floor.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; Working in partnership with others; Continuous learning and improving care

At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service which placed people at risk of harm. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- At our last inspection we found quality monitoring systems were not consistently robust or effective in identifying and driving improvement needed. At this inspection we found this had not improved.
- Whilst the provider had made improvement needed where CQC had identified shortfalls, their quality monitoring systems were not effective in identifying further improvements. The provider relied on CQC for their quality monitoring which is not appropriate or robust.
- This meant at this inspection we found the provider's systems for quality monitoring had failed to identify shortfalls. For example, the MCA audits completed in December 2022 had not identified the lack of evidence available to demonstrate decision-making. Weekly medicines audits completed in December 2022 had not identified the shortfalls we found with medicines management. Kitchen audits had not identified concerns with cleanliness.
- On the first day of inspection we found the provider was displaying the wrong rating both externally and internally. The provider was rated requires improvement and was displaying a rating of good. We asked the provider to remove the good rating and found they were not aware they had to display their most current rating from CQC. They removed the wrong rating during the inspection.
- The provider had failed to notify CQC of incidents and events they are required to by law. We found the provider had not notified CQC of DoLS approvals, safeguarding incidents and one incident involving the police. The provider was not aware they had to submit notifications to inform CQC of these incidents. Monthly management audits completed by the provider, recorded all CQC notifications had been submitted. This was not accurate and placed people at risk of further harm.
- Not all safeguarding concerns had been reported to the local authority safeguarding teams. This meant they were not able to carry out any investigations to keep people safe.
- Systems in place to monitor and mitigate risks were not effective. For example, the provider carried out weight analysis. This helped them identify who was losing weight and at risk of malnutrition. We found their measures in place to mitigate risks was for people to have a fortified diet. However, the kitchen staff were

not aware of who needed a fortified diet and had out of date information about people's weights.
● The provider had not carried out any call bell monitoring to monitor response times. They had also not carried out any checks out of hours following an incident where night staff had been seen sleeping on duty.
● When we raised incidents of poor practice we observed with the provider, they told us staff did not follow their policies. The provider was not able to demonstrate action they were taking to address this significant concern. Systems in place to assess quality and safety did not include observing practice and people's lived experiences of care.
● The provider had failed to demonstrate they were able to identify the improvements needed and have robust systems in place to achieve a good rating.

Failing to assess, monitor and improve the quality and safety of the service, failing to assess, monitor and mitigate risks relating to the health, safety and welfare of people placed them at risk of harm. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was no registered manager in post. A new manager had been employed and was going to apply to register with CQC.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We observed people's experiences of care were not always person-centred and of a good quality. Examples of this included one person told staff they were uncomfortable and in pain. Staff did not respond to this person, so we intervened and asked them to. We observed staff then move this person further up in their chair without engaging with the person or asking their consent.
● We observed staff stood in the lounge watching people or the television. One member of staff was stood with their arms folded. There was little attempt to interact or engage with people in the lounge at times. Staff were responding to one person by calling out answers to their questions. When doing this staff were not looking at the person or stopping what they were doing to engage with them.
● Two members of staff brought one person into the lounge in a wheelchair. They talked to each other as to where they should 'put' the person. They did not ask the person where they wanted to sit.
● Staff continually told one person to sit down. The person was sat at a dining table and wanted to get up. Staff told them to "sit". This interaction was not meeting the person's needs.
● We also observed experiences of poor care during a mealtime which we have reported on in the key question effective.

Failing to provide people with care that met their needs and reflected their preferences placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives we spoke with told us they thought their family member received good care from staff. One relative told us, "They [staff] are very good, [relative]'s health is good, they eat well and are clean and tidy." Another relative said, "They [staff] are fantastic, it is a small care home, they know [relative], they know their character. They develop an individual relationship with their residents."
● Whilst the manager was new the day to day management was carried out by the nominated individual. People and relatives were complimentary about their approach. One relative said, "I like it that he is on site and does not leave it to a manager, he is there. Every time I go in he is there, and approachable. He is a nice person."

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

● There was a duty of candour policy in place. There had been no incidents which required a response under duty of candour.

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

● The provider had carried out surveys for people, relatives and staff in August 2022, but was not able to provide evidence of what they had done in response.

● Whilst most feedback received was positive, there were some issues raised. For example, 1 relative had recorded their family member wore 'random clothes' and had a smell in their room. We were not able to see any action taken by the provider in response to this feedback. We noted in one person's room they had an item of clothing belonging to another person. The provider told us when people passed away items of clothing were shared amongst other people.

● One member of staff had responded 'no' to a question in the staff survey asking if they thought 'resident's needs were met to a high standard'. The provider had failed to investigate this feedback.

● Despite the shortfalls we found during the inspection, people and relatives told us staff were friendly and approachable. One relative said, "They [staff] are always friendly and approachable. I am happy to approach them and never questioned their approach."

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<br><br>The provider had failed to make sure people received care in line with their needs and that reflected their preferences. This placed people at risk of harm.<br><br>Regulation 9 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to make sure the legal requirements for seeking consent were followed. Where people lacked capacity records of assessments and best interest decision making had not been completed.<br><br>Regulation 11 (1) (3) |

| 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<br><br>Systems were not in place to make sure people were safeguarded from abuse and improper treatment. This placed people at risk of avoidable harm.<br><br>Regulation 13 (1) (2) (3) (4) |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to demonstrate they had provided appropriate support and training to staff to enable them to carry out their duties. This placed people at risk of harm.

Regulation 18 (1) (2) (a)

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<br><br>The provider had failed to make sure risks to people's safety were assessed and management plans in place to keep people safe. The provider had failed to make sure staff had the skills and competence needed to support people safely. The provider had also failed to manage people's medicines safely. This placed people at risk of harm.<br><br>Regulation 12 (1) (2) (a) (b) (c) (g) |

**The enforcement action we took:**

We served a Warning Notice to the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to put into place effective systems to assess, monitor and improve the quality and safety of the service, to assess, monitor and mitigate risks to the health and safety of people. This placed people at risk of harm.<br><br>Regulation 17 (1) (2) (a) (b) |

**The enforcement action we took:**

We imposed a condition on the providers registration.