Parkview Care Homes Limited

Parkview Care Home

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Parkview Care Home is a residential care home providing personal care and support to people experiencing complex or enduring mental health difficulties. The service can support up to 10 people, at the time of inspection there were seven people living at the home.

Parkview Care Home accommodates people in one adapted building across four floors. The building is in a residential area of the city close to public transport and public recreational areas.

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

There was a lack of management and provider action to ensure safety concerns around the building were addressed. The provider had not responded to recommendations from their own audits to maintain the environment. Maintenance and repairs were needed but not scheduled. Some areas of the home needed actions to meet fire safety regulations and reduce avoidable risk of harm. The provider had not prioritised the reduction of these risks. Following our inspection the provider started to take actions to address the risks identified.

Infection prevention and control was not well managed and there was a lack of leadership to ensure people were protected from the risk of infections. The local authority were providing advice and guidance about safe deployment of staff and good infection prevention and control measures.

Medicine was not always managed safely. Medicine administration competency assessments were overdue and not all support staff had completed medicine awareness training.

There was poor governance of safe staffing numbers, recruitment, support or training to staff. There were sometimes not enough staff working to double sign controlled medicines so managers had advised staff to call on colleagues from another service nearby to support them when required. Staff had not always received the mandatory training they needed and there was no specialist training to reflect the needs and risks of people at the service.

Person centred risk assessments, risk management and support was not evident in people's care plans. Care and support was not regularly reviewed to ensure people's goals and changing needs were understood and supported. Incidents and accidents were not analysed in order to find ways to reduce risks.

Systems were not managed well to improve the service. Quality assurance audits were carried out by the provider, but there was no leadership or drive to reduce risks or improve the quality of care offered to people.

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

Rating at last inspection
The last rating for this service was Good (published 8 November 2019).

Why we inspected
We received concerns in relation to infection control, governance and staff support. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to fire safety, infection control, medicine management, staffing, recruitment, person centred care and governance at this inspection.

Please see the actions we have told the provider to take, and enforcement action we have taken, at the end of this report.

Follow up
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.

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

Parkview Care Home

Detailed findings

Background to this inspection

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

Service and service type
Parkview 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection and we sought feedback from the local authority. We reviewed information gathered through our monitoring activity and monitoring call with service managers.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
The registered manager had recently left the organisation, there was a manager in place who was not registered. We spoke with three members of staff, including the manager.

We spent time observing how people and staff interacted and how people spent their time at the home. We observed the administration of medicines. We sought updates from the interim manager following our direct monitoring call. We reviewed a range of records including safety and maintenance records and provider audits. We looked at three people's care plans.

After the inspection
We continued to seek information and clarification from the manager about staff records, policies, infection prevention and control. We reviewed the four staff recruitment records sent to us. We spoke with the compliance manager about audits, we spoke with the area manager to validate evidence found and establish what actions were being taken to address concerns found. We spoke with three care staff and three health and social care professionals who regularly interact with the service. We spoke with the local authority about infection prevention and control concerns. We spoke with the fire service about fire safety concerns.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks found in the home environment were not acted on and people were placed at risk of harm. Fire Risk Assessment recommendations were made to the provider in April 2021 to improve and add fire doors and improve fire safety measures, these had not been followed. The provider had been given a recommended timeframe for improvements, June 2020, which they had not actioned. There was no schedule in place for improvements to be made and lessons were not being learned from risk assessments.
- The environment had not been properly maintained. Compliance audits over the last year had made recommendations for improvements to maintenance, décor and safety around the home which were not actioned. For example, flooring and sealant in bathrooms needed replacing, doors and frames around the home were worn and needed assessing for safety and cluttered furniture in communal areas needed to be cleared for fire safety and access.
- The home was not being kept clean. There was no cleaning schedule in place and the manager had not ensured housekeeping tasks were staffed. Carpets and flooring needed cleaning, bathroom equipment and sundries needed replacing. There was no regular cleaning of high touch points around the home.

The provider had failed to ensure the premises was properly maintained, standards of hygiene upheld and health and safety risk assessments acted on. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we asked the provider for a schedule of maintenance, repairs and actions in response to fire safety and maintenance concerns. Some key actions have not yet been completed. We have made a referral to the East Sussex Fire Service for further audits of fire safety requirements to take place and asked the provider to provide a schedule of actions to address fire safety risks identified. The provider has started to take actions to address these risks.

- Risks relating to people who smoked were not clearly identified and managed. One person who used an emollient cream for their skin did not have the risk of ignition assessed and reduced. We raised this with the interim manager who told us they would carry out a risk assessment and seek advice from the GP. People who smoked did not have individual risk assessments to identify and reduce risks of fire starting in their rooms through the use of lighters and matches. Some people were known to smoke in their rooms. We found that apart from warning letters there were no proactive risk reduction measures in place.
- Incidents and accidents were not recorded, analysed or acted on to reduce harm to people. There was no

incidents and accidents log. Where we had been notified of injuries and incidents, this was due to alerts being raised by the ambulance service. These risks had not been analysed and the registered manager had not reviewed risk plans or staff skills and training needs. Staff told us they had not recorded incidents and accidents because they had not been told how to recognise and record these events until very recently.
● Where people needed harm reduction or risk management plans for behaviours which challenged or resulted in self-harm, staff did not have necessary training or confidence to respond. People's care plans did not have up to date risk assessments or plans to minimise harm. Staff told us they had not received training to recognise or respond to first aid, self-harm behaviours, mental health crises or emergencies. This meant people's risks or behaviours could escalate, placing them and others at risk.

The provider had failed to ensure that people were protected from the risk of avoidable harm. Although there was no evidence people had experienced avoidable harm, they were at increased risk. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager to send us completed risk assessments to show how risks related to the use of emollient creams would be managed, particularly for people who smoke. These were completed after our inspection and showed that advice from a health professional had been sought about alternative creams.

Staffing and recruitment
● Staffing levels were not managed safely. There was no system or method in place to calculate safe staffing levels according to people's needs and risks. This meant there was no system to identify when staffing levels were unsafe or needed reviewing. Staff told us they had been asked to complete the rota themselves despite having no training or tool to calculate safe staff numbers. Staff told us they had regularly worked the night shift on their own and had not felt safe managing people's needs and risks on their own.
● There were not always enough staff working with the right mix of skills to meet people's needs. For example, there was not always a member of staff on duty who had passed their medicine competency assessment. The provider had advised staff to ask a colleague working in their other service to come into the building so that medicine administration could be double signed when required. Staff told us night carers had regularly worked on their own when two carers were needed for medicine administration.
● Staff absence had not been addressed sufficiently or according to absence management protocols. Housekeeping hours had not been covered which meant there was no time for cleaning tasks to take place. We saw records that staff had been absent from work, however, there were no records of return to work interviews or support for staff returning from sick leave. There were no health and safety risk assessments carried out with staff on return to work and no evidence that any concerns about absence had been addressed.
● We found that there was a reliance on staff from the provider's other service to work shifts at Parkview Care Home in order to fill the rota. Staff told us they felt some staff were stretched between the two services working excessive hours, because there were not enough staff employed. One staff member had been working excess hours without any monitoring or management of their or others safety. The interim manager told us there had been no governance of risks to staff wellbeing regarding hours worked and was limiting this. The movement of staff in this way between care homes went against current government COVID-19 guidance on the safe deployment of staff – please see the Effective key question for further details.

The provider had failed to ensure there were sufficient numbers of suitably trained staff. This placed people at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they were reviewing staffing structures across their services for both care staff and management. The provider is seeking further advice and guidance from the local authority about the deployment of staff across their services.

● The provider did not have a robust recruitment process. Safe recruitment practices had not been followed and records of recruitment were either not available or incomplete. One the day of the inspection staff recruitment records were not accessible to the interim manager and could not be shared until after the inspection visit. We found interview records were absent, employment histories, with gaps in employment explained, were not gained, reasons for leaving previous care work was not followed up.

The provider had failed to ensure safe recruitment processes were operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager told us they would ensure forthcoming recruitment followed established policies and processes.

Using medicines safely; preventing and controlling infection
● Infection prevention and control measures were not consistent or robust. There was no cleaning schedule in place and staff were not regularly carrying out cleaning tasks.
● There were no records of COVID-19 staff test results, the registered manager had no governance of staff COVID-19 testing and the interim manager had no evidence that staff had regularly been tested.
● Visitor's COVID-19 test status or potential symptoms were not checked on entry. Visitors traveled through the building and to another floor before signing in which meant all visitors had passed people's bedrooms and through communal areas before any checks were made.
● We found that staff and managers routinely worked between two services during their shifts. This movement of staff went against current government COVID-19 guidance which recommends a limit to this practice to reduce the spread of infection.
● We saw a member of staff was not wearing a face mask, this was not addressed by the interim manager until we spoke with them about it. One member of staff was not wearing a facemask provided by the service. The interim manager had not checked if the mask complied with government guidelines for the recommended type of mask to be used in care homes. We saw that PPE was not always changed by staff when they worked between services during their shifts.
● The provider's environmental audits had identified actions for improvement in cleanliness and hygiene over several reviews, but these had not been actioned. Concerns ranged from cluttered and unclean communal areas, unhygienic sanitary ware in bathrooms, unclean areas of the kitchen and general maintenance and décor actions.
● There were no records of any cleaning or hygiene checks carried out by the registered manager to ensure safe practices, identify improvements needed or plan actions. We asked for the manager's quality assurance audits, but these could not be found.
● Some aspects of medicines had not been managed safely. The provider's compliance audits had identified repeated medicine errors, such as gaps in recording accurate stock counts. The audits indicated staff needed further training and support, but there was no scheduled training in place.
● Staff medicine administration competency assessments were out of date for three staff. Not all staff had completed medicine awareness training. We were not assured that all staff supporting people with their medicine were competent and confident to do so.
● There were no risk assessments in place to show when people could not manage their own medicines or when they needed support. We saw one example where a person self-administered some, but not all, of

their medicine, there was no record to show why this was or what the risks were. The staff member and interim manager we spoke with did not have any information to understand when people could and could not self-administer their medicine.

The provider had failed to ensure the proper and safe management of medicines and the control and prevention of infections. Although there was no evidence people had come to harm, they were at increased risk. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- There were safeguarding policies in place and staff told us they understood their responsibility to report safeguarding concerns. However, because the significance of incidents and accidents had not been understood or recorded in the service, we were not assured that people's experience of abuse would be recognised and acted on.
- Safeguarding training was not robustly managed. There was mandatory training in place for safeguarding awareness, but most staff had not completed the initial or refresher training. The interim manager had given staff a deadline for completion and was following this up.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not all undertaken the mandatory training set out by the provider and had not received specialist training relevant to meet people's needs. The staff training matrix showed that most staff were not up to date with key knowledge, such as infection control, safeguarding, fire safety and working with equality, diversity and inclusion. Most staff had not received training in areas such as managing behavioural risk, complex mental health needs or first aid. Staff told us they had no opportunities over the last year to discuss their development or training needs for their role.
- Staff had not received regular support through supervision, appraisals or staff meetings. There were no records of individual or group meetings between the registered manager and staff. Staff we spoke with told us they had few opportunities for receiving formal feedback about their role, to discuss the support they provide to people or to raise concerns. Staff told us they had recently raised concerns and grievances due to the lack of support they had received.
- Staff we spoke with told us they did not have an induction when they started their role. There were no records of staff probation, staff receiving an induction programme or supervision to ensure new staff understood their role and carried it out safely.
- Staff told us they were interested in learning and developing their skills and knowledge with national care qualifications. However, they told us their training had not been encouraged or facilitated over the past year.

The provider had failed to provide staff with appropriate support, training, appraisal and supervision to carry out their role. This placed people at risk of receiving care and support which was not effective. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager had recently held an initial staff meeting to discuss staff concerns, they told us they would develop plans to support staff.

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

- People's support did not always support their independence and growth. There were minimal references in people's care plans to their aspirations or motivation towards self-managing their daily living tasks. Staff told us people had tasks completed for them rather than with them and their independence was not

promoted as much as it should be. Staff said some people had become reliant on staff for tasks like planning and preparing meals when they could have managed these more independently. One person told us, "When I need something doing, like my washing or stuff around here [the house], staff do it. I come and go as I please, I like that, but staff don't teach me, they just do it."

● Care plans did not reflect people's current rehabilitation goals. We saw some people's goals, agreed tasks and risk assessments had not been updated for several years. Support was not recorded on a daily basis, so it was not clear what support was provided and how this was experienced by people. People's progress in reaching goals or development was not monitored or recorded. Staff told us there had been little leadership or audit or care plans to ensure support was proactive and responsive to people's needs.

● We saw little evidence that people had directly contributed to their care plans or reviews. One example of this was in decisions made about whether people self-administered their medicine. There were no records showing how the service had decided people could not safely self-manage their medicines or how often this should be reviewed. Staff did not know how these decisions had been made, there were no risk assessments showing these decisions with people.

● People we spoke with liked living at the home, but they did not always feel involved in how care and support was provided to them. One person told us, "I do like it here, but I don't know all the staff. I don't know if they know me, but they seem nice. I don't know if there are any plans, I just come and go." Another person said, "I don't think things are reviewed, I've lived here for [many] years, I like it, but I don't think there's a plan."

● People's care plans did not always recognise their physical health needs alongside their mental health needs. People's health needs had not always been reviewed regularly so changes were not picked up in a timely way. Staff gave us examples of increasing skin health and mobility needs which were not routinely discussed with people. One staff member told us, "I don't think [physical health] was seen as a priority, you'd find out people were struggling over time by noticing changes but I think there should be more planned conversations with people about their physical health and wellbeing".

● People's community-based health professionals told us the service had previously been good at communicating changes in risk and need but this was not as good as it had been. Health professionals we spoke with were not always confident that staff understood actions and plans for people.

Care and treatment was not always person centred or focussed on their goals. This placed people at risk of receiving care and support which did not meet their needs. This was a breach of regulation 9 (1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the interim manager told us they were planning to bring in a keyworker role so that people had a particular member of staff to get to know them well and review their needs. The interim manager was in the process of booking reviews with people's community-based professionals. We will ask the provider for an action plan to improve how well support is person centred.

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

● The home décor needed cleaning and maintaining. Some areas of the home, such as carpets, walls, woodwork and doors were worn and needed cleaning and maintaining. The provider has been asked to draw up a schedule of actions to improve the maintenance and hygiene of the home. Please see the 'Safe' section of this report.

● Some aspects of the building were homely. Communal areas and stairwells showed posters, art and crafts made by people who lived at the home. There was a garden which people told us they really liked and found peaceful and calming.

● People made decisions about where they wanted to spend time, either in their bedrooms or communal areas. People told us, "I really like the garden, especially in summer, we're really lucky to have it." Another

person said, "We're free to go where we like and spend time how we want, people do what they like, it's good. You can watch the TV in the lounge or play games at the dining table. I like it."

Supporting people to eat and drink enough to maintain a balanced diet
● Most people did not have nutritional support needs, but some people needed encouragement to develop cooking skills. Care plans lacked goals and tracking relating to independent cooking and food management skills. People told us they were not always involved in cooking. Staff we spoke with told us, "The culture in the home has slowly become more about serving people than encouraging people to develop cooking skills, we need to get back to that."
● People's preference and choice of diet was recorded in their care plan or recent resident feedback forms. People said they generally liked the meals they ate. There was a drinks tray in the dining room for people to help themselves to cold drinks or make hot drinks.

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).

● Staff had not all received mandatory training in applying the MCA assessments and DoLS. The staff we spoke with understood some of the principles of the MCA and that people needed to have their mental capacity assessed if it appeared they lacked mental capacity to make decisions about their care and support.
● At the time of inspection DoLS did not apply to any people.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- There was no registered manager in post. The registered manager had left in September 2021. At the time of inspection, there was an interim manager who intended to apply to be the registered manager, an application had not yet been submitted. The service did not have a deputy manager role, the provider told us they were reviewing staff and management structures for the home. A compliance manager based with the provider's head office carried out periodic audits of the service.
- The registered manager and provider had failed to ensure Fire Risk Assessment requirements were actioned by the recommended date or scheduled for completion. We asked the provider for a schedule of actions to meet the required improvements but dates for significant actions such as fitting and improving fire-doors were not provided. We have asked the East Sussex Fire Service to contact the provider for further advice and support to reduce fire risks.
- Staffing was not well-managed. There were no records for staff support, absence management or disciplinary processes. Staff told us they did not have regular supervision, meetings or formal support from the registered manager. Staff sick leave was not managed to promote staff wellbeing, identify staff health needs or ensure continuity of service provision. The provider had not identified or responded to this shortfall over the year.
- Risks to people were not well-managed. Incidents and accidents were not logged, staff had not been trained in recording these and told us they needed more guidance about what to record. Risks and potential causes of harm to people were not clearly identified, mitigated or reviewed by the manager. There had been no leadership in ensuring staff were well trained and supported to respond to risks.
- There was no management oversight or analysis of how people's care or systems or could be improved. We found no audits or checks carried out by the registered manager to establish the quality of care and support. The provider confirmed there were no quality assurance records at the home. There was no plan in place to drive improvement across the service.
- Provider audits and actions for improvements had not been acted on. The provider's audits over the last year did not lead to the necessary changes and improvements to the environment or systems. Many of these concerns remained unactioned at the time of inspection. We have named the areas of concern in the safe section of this report.
- Staff felt unsupported by management and the provider. Staff told us they had raised concerns about how the service was managed, and how they were supported, earlier in the year. They told us they had not seen any changes until the interim manager was in place over the last month. Staff had not been supported with

supervision or appraisals and had not undertaken mandatory training when required.
● There was no Statement of Purpose in place to identify the values and goals of the service and enable people and staff to understand what they could expect from the service. Staff told us the remit of the service had become vague and long term rather than focused on enabling people to develop independence. One member of staff told us, "It's just not very clear what the service is here to do and there is nothing to refer to."

The provider had not ensured systems and processes operated effectively to maintain governance of the service and compliance with their responsibilities. This was a breach of regulation 17(1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us a new Statement of Purpose after our inspection, this set out the aims and objectives of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People's views had not been regularly sought or responded to. Audits by the provider had not identified that people had made no contribution to service delivery or improvement.
● The registered manager had not sought the views of staff or professionals to improve the service. There were no records of feedback surveys, comments or complaints from staff, people's family, friends, representatives or other professionals. Staff told us their views had not been valued and concerns raised to the manager about low staffing, training to manage risk and lack of support were not responded to. Staff told us when supervision and staff meetings stopped, they had no formal forum to share concerns.
● External professionals experiences over the past year were mixed. Professionals told us staff had good intentions but that the service had deteriorated and did not always communicate or respond to people's changing needs in a proactive way. Several professionals told us that communication to the service about people's changing risks and support needs was not reliably recorded or responded to.

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
● Due to the lack of incident recording and analysis we were not assured that the provider had applied their duty of candour if things went wrong.

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 The provider had not ensured people's care was person centred and achieved their preferences and needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines and the prevention and control of infections. The provider had not ensured there were systems and processes in place to ensure people were protected from avoidable harm such as incidents and accidents and behaviour support plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems and processes operated effectively to maintain governance of the service and compliance with their responsibilities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure safe recruitment processes were operated

effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably trained staff. The provider had failed to provide staff with appropriate support, training, appraisal and supervision to carry out their role.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises was clean and properly maintained. People who use the service and others were not protected against fire safety risks identified in a Fire Risk Assessment. The provider had not taken action to address concerns raised by environmental audits carried out over the last twelve months. The provider did not have a full schedule in place for improvements and repairs. The provider did not have a Statement of Purpose in place to describe the current values and purpose of the service or contact details for registered people.

The enforcement action we took:

Warning Notice issued. Schedule of actions and improvements to be made.