Sandstone Care Telford Limited

The Farmstead

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Farmstead is a care home providing nursing and personal care to up to a maximum of 66 people. The service provides support to older people, younger adults, people with dementia, physical disabilities and sensory impairments. At the time of our inspection there were 34 people using the service.

The Farmstead is a purpose built care home. Each of its 3 floors has its own communal dining and lounge areas with a kitchenette. A passenger lift gives people access to all floors.

People's experience of using this service and what we found
People were placed at risk of harm because the provider failed to ensure people's medicines were managed and stored safely. People were not protected against the risk of abuse because staff did not always speak up about poor practice and witnessed abuse. Safe infection prevention and control measures were not followed by staff. Lessons had not always been learnt when things had gone wrong.

There was a lack of oversight and direction to ensure staff had the competence and understanding of what they needed to do. Although staff had received training, they did not always put this into practice.

People were at risk of poor health outcomes because staff did not always make timely referrals to health professionals or provide them with sufficient information.

The provider had failed to act in accordance with the Mental Capacity Act (MCA) to gain consent for the use of people's photographs on social media. People were not always supported to have maximum choice and control of their lives and staff did not always support them in their best interests; the policies and systems in the service were not supported by staff practice.

People were not always treated in a compassionate, respectful way. Some people experienced inconsistencies in the caring nature of staff who supported them.

The provider had a complaints procedure in place, but this was not always followed. Improvements were needed to ensure people's end of life wishes were discussed and recorded.

The provider's audit and governance systems were not operated effectively and known issues continued to occur. The culture at the service did not support people's safety, choices or the management of risk and there was a lack of accountability from staff when they were aware of poor practice. Feedback from community professionals did not support a well-led service.

People's preferences were recorded in their care plans along with what was important to them. People were supported to spend their time how they wanted to and to be involved in activities if they wished to.

Despite our findings at this inspection, most people were happy with the care and support they received and gave us positive feedback about the staff and management at the home.

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

Rating at last inspection
The last rating for the service under the previous provider was good, published on 21 April 2022.

Why we inspected
The inspection was prompted in part due to concerns received about medicines, how the service supported people's health and care needs and poor engagement with community professionals. A decision was made for us to inspect and examine those risks.

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.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to how people's safety was managed, how people were safeguarded from abuse, consent and how the service was managed 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
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not 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

The Farmstead

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
The inspection was carried out by 3 inspectors, 1 inspection manager and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Farmstead 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. The Farmstead is a care home with 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. They had recently left but were still registered with us. An interim manager had been at the home for 3 days prior to our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. We received feedback from the local authority, local Healthwatch and professionals who work with the service. We used all this information to plan our inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people, 7 relatives, 16 staff which included support staff, care staff, nursing staff and managers. We also spoke with the nominated individual and one of the directors. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 10 people's care plans, medicine administration records (MAR) and 3 staff recruitment files. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

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.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected against the risk of abuse. We found instances where staff had not spoken up about poor practice and witnessed abuse, despite having received training on how to recognise and report concerns.
- We made a safeguarding referral to the local authority during our inspection when we found staff had not acted on a person's health concern. Staff had recorded a significant weight loss for one person yet had not taken any action or escalated this concern.
- The provider had policies in place however, not all staff followed these policies to ensure people were protected from potential abuse.

The provider had failed to take action to safeguard people from the risk of abuse. This is 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.

Using medicines safely

- People's medicines were not managed safely. Some people had their medicines administered via a patch which was applied to their skin. Staff had not followed the manufacturer's and pharmacy direction to ensure the site of administration was changed. If patches are applied to the same skin site the person can experience skin irritation and it can also affect the medicine's effectiveness.
- People's medicines were not stored safely. The monitoring of medicine fridges and medicine rooms temperatures was not consistently completed. One medicine room's temperature was at an unsafe temperature for a prolonged period of time which could affect the effectiveness of people's medicines. Despite staff being aware of this, no action had been taken to ensure the safety of the medicines being stored. When we highlighted this to the provider, they took timely action to address this concern.
- There was no risk management or support for one person who had been administering some of their own medicines. We found some of their medicines, which were kept in their room, had passed their use by dates and staff were not aware of one of these medicines. Staff had also signed to say they had administered this person's medicines when they had not. The provider could not therefore be assured the person had received their medicine as prescribed. This placed the person at risk of harm.
- Some people had medicine given to them only when they needed it, such as pain relief or medicine to help calm them. There was no clear guidance on how or when these should be given. This placed people at risk of receiving these medicines in an unsafe manner because staff did not have sufficient guidance to follow.

Preventing and controlling infection

● We were not assured the provider was using personal protective equipment (PPE) effectively and safely. Staff and managers were seen without masks on multiple occasions and when questioned did not understand the guidance they should follow. We saw staff regularly pulled their masks down to talk but then did not practice hand hygiene or change their masks to help reduce the risk of cross infection. This placed people, visitors and other staff at risk of harm.
● We were not assured the provider was preventing visitors from catching and spreading infections. Visitors were given inconsistent or no instructions when they arrived at the home as to what hygiene practices they should follow. Government guidance was for visitors to be encouraged to wear face masks, but this was not put into practice. The provider had no clear protocol and staff were not clear on how this guidance should be implemented.
● We were somewhat assured the provider was supporting people living at the service to minimise the spread of infection. We found managers were not clear on the current Government guidance in place.
● We were somewhat assured the provider was responding effectively to risks and signs of infection. The provider could not evidence risk assessments had been carried out on people and staff belonging to higher risk groups or the action they had taken to reduce the risks of infection.
● We were somewhat assured the provider was making sure infection outbreaks were effectively prevented or managed. On the day of our inspection staff attended a meeting at the home. During this meeting, we observed poor mask wearing practice from staff which increased the risk of cross infection between staff.
● We were somewhat assured the provider's infection prevention and control policy was up to date. Although the provider had an up to date infection control policy in place, we found an inconsistent approach towards visitors, risk assessments of those who were clinically vulnerable to infection and staff's poor practice in relation to mask wearing.

Assessing risk, safety monitoring and management
● We found torn carpets on one floor of the home which provided a risk of trips or falls for people, visitors and staff. Although we saw evidence an external contractor had been contacted to replace the carpet the provider had taken no action to remove the immediate risk.
● We found one emergency exit which was partially obstructed by equipment. This could hinder a quick and safe exit in case of an emergency putting people at risk of harm.
● We found items which could pose a risk to people, such as cleaning and pest control substances were stored in communal areas in unlocked cupboards. Despite these cupboards all having lockable doors, staff told us these were never locked.

Learning lessons when things go wrong
● The provider's systems were not wholly effective to ensure the risk of recurrence was reduced when incidents happened at the service. Learning from when things went wrong was not promoted in a way that staff learnt from, for example the service had a high instance of medicine errors which continued to occur and safeguarding incidents may have been avoided if action had been taken.

The provider had not ensured the safe management of all medicines. There was a failure to protect people through infection control practices and the monitoring and management of risks. Lessons had not been learnt when things had gone wrong. This put people at risk of harm. This is a breach of regulation 12 (safe care and treatment) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider sent us evidence of the interim measures they had put in place to reduce the risk of trips and falls from the damaged carpet. This was whilst they waited for the carpet to be replaced.

The provider took timely action during our inspection to ensure the emergency exit was cleared and the cupboards where the substances were stored were able to be locked.

Visiting in care homes
The provider's approach to visiting at the home did not align with Government guidance at the time of our inspection. There was also no information displayed or discussed with visitors about not entering the home if they felt unwell. By the second day of our inspection this had been addressed. After our inspection, the provider told us they sent guidance to families on a regular basis to inform them of the visiting arrangements.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.

● Staff understood the risks to people, how to report accidents and the action they needed to take should a person have an accident, such as a fall.

Staffing and recruitment
● Improvement was needed in the deployment and oversight of staff at the home. Staff did not always have the skills, competence and experience to lead each shift and support people to stay safe. Managers and the provider did not therefore have sufficient insight and understanding of events within the home.
● The provider used agency staff to cover shortfalls in staffing at the home. The provider had tried to ensure a consistency of the agency staff used but this was not always possible due to changes made by the agency.
● Despite our findings, most people told us they felt safe when receiving care from staff and they got support when they needed it. One person said, "Staff are always busy but they always ask how you are and find time to make you a drink."
● Some staff recruitment files contained gaps in required information which included previous employment histories and dates. The provider took action to address this as soon as we made them aware.
● Registration details for nursing staff were checked with the Nursing and Midwifery Council to ensure these were valid and current.
● Staff had Disclosure and Barring Service (DBS) checks completed prior to starting work at the service. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment 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.

- We were not assured the provider had followed the MCA principles when photographs of people were used on social media. Where people lacked capacity to give their informed consent no capacity assessments or best interest decisions had been completed. Although consent was gained from people who did have capacity, these records were not always complete.
- Although staff understood the importance of gaining consent from people, their knowledge of the MCA needed improvement. Staff had received training in the principles of the MCA but, had not always put their learning into practice.
- The provider had systems in place to assess, review and report on people's mental capacity and decision making abilities. However, records did not always show how decisions made for people were deemed to be in their best interests.

The provider had failed to ensure people's rights were protected. This is a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to

maintain a balanced diet
● People were at risk of poor health outcomes because staff did not always make referrals to external health care professionals in a timely manner. Staff had recorded a deterioration in one person's skin integrity yet had not sought advice.
● One person's relative told us they had concern about their family member's health. They told us staff were slow to act on health care needs and information from the family did not get passed on and actioned.
● One person's care records stated they had a poor diet and were at a high risk of malnutrition. There was no plan in place to manage this risk and staff records of what the person ate were not detailed enough to be able to monitor their intake effectively.
● Feedback we received from community professionals was mostly negative. They told us when they visited the home staff did not always have up to date or accurate information available, medicines had not been given as prescribed and staff had not always carried out previous care instructions.
● Where staff had made referrals to other agencies, these did not always contain accurate information to enable the healthcare professional to make appropriate assessments of the person's health.

These issues constitute a breach of regulation 12 (safe care and treatment) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they enjoyed the food they had and received the support they needed. One person told us, "If you ask for a different food, they will sort it for you if they can."
● We saw people had drinks available to them throughout our inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Not everyone had an oral health assessment and care plan in place. The nominated individual told us all care plans were currently being reviewed and updated so this deficit would be addressed. However, until this was done the provider could not be assured everyone received appropriate support with oral care.
● People's care and support needs were assessed and care plans were in place. However, some people's care plans needed updating and the provider was already aware of this. The provider told us they had prioritised this and ensured those with the most complex needs were reviewed and updated first.
● In newly updated care plans we saw the use of national best practice tools to assess and plan people's needs.

Staff support: induction, training, skills and experience
● Staff received the training they needed to ensure they had the skills, knowledge and experience to deliver effective care. However, staff had not always put this learning into practice for the benefit of people who lived at the home.
● Staff who were new to working in care had not always completed their Care Certificate. The provider told us this had been paused since they had taken over the home. 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.
● The provider had made improvement to staff training since they had taken over the home. A Local Authority quality monitoring visit in September 2022 had identified areas where improvement was needed to staff training. The provider had responded to this and had either delivered or arranged for the training to be delivered.
● The provider had also made improvement to how they monitored and assessed staff competencies with nursing tasks and medicine management. However, despite these competency assessments being done, people did not always receive effective care.

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

● The service design did not always meet the needs of people living with dementia. Signage to help people orientate around the home was limited.

● The provider told us they knew the environment needed improvement. They were currently working with an external organisation to help them make the improvement needed.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- We found wide-ranging concerns during our inspection which did not demonstrate a caring approach from all staff at all times, such as not reporting poor practice which could put people at risk of harm.
- We received mixed feedback from people and relatives about the way in which they were supported and treated at the service.
- One person told us, "Staff are friendly, how they respect me is nice. Staff will wash me and shower me gently and carefully." Another person told us they thought staff could be "a bit rough" when they were busy.
- People told us staff sought their permission before providing personal care.

Supporting people to express their views and be involved in making decisions about their care
- People were not always involved in decisions about their care. One person had a decision made for them about what they wanted for their lunch. The person was not supported to understand what their choices were and so the decision had been made for them.
- Some people told us they had been offered a choice of gender of the staff providing their care. However, we were aware people were not always supported in line with their choice. This had resulted in some people not being happy with the way in which they were supported.

Respecting and promoting people's privacy, dignity and independence
- We saw both positive and negative interactions throughout our inspection between staff and people. This included staff comforting and giving people time to express how they felt but also not respecting people's privacy. We saw some staff did not knock on people's doors before entering their rooms.
- One person who was in their room, was left in an undignified situation whilst a staff member went to get some PPE. The staff member could have closed the person's door whilst they went to get their PPE but chose to leave them in full view of anyone who walked past. We also heard the staff member say to another staff member that they were just going to "sort [person's name] out". This practice and language did not demonstrate respect for the 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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Some staff told us they did not have time to read people's care plans however, staff could tell us how they supported people and were aware of risks. Staff told us they did not find care plans to be accessible and relied on hand overs and other staff for direction on how to support people along with getting to know them.
- People's preferences were recorded in their care plans along with what was important to them. They gave information on how staff could support people if they became anxious.
- People's care plans were reviewed monthly by nursing staff. However, we found some people's care plans were not reflective of their current health, such as weight loss. This could prevent people's health needs being met.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Information on people's communication and accessible information needs was not always detailed, such as how to support people to make choices. This would be a barrier to people being able to make their own choices and decisions about their care and support.
- People's care plans identified their sensory needs including poor vision and hearing. They gave information to staff on how they could support people such as talk louder or clearer and how to fit and use a person's hearing aid.
- Although staff told us information was available in accessible formats such as pictorial and large print we did not see evidence of this throughout the home.

Improving care quality in response to complaints or concerns

- The provider had a complaints procedure in place but we found this was not always followed.
- The provider investigated complaints which were made, but the complainants did not always receive acknowledgement or feedback on the outcome of their complaint. One complainant had not been informed of how their complaint had been resolved. Another complainant told us they had not received any acknowledgement from when they had made a complaint.
- Staff did not always escalate people's complaints to managers for investigation. One person told us they were confident in the way their complaint had been handled by a staff member who told them they had

"sorted it". However, the provider was not aware of this complaint.

End of life care and support

● Some people's end of life care plans stated families were to be contacted should the person's health deteriorate or they become end of life. People's end of life wishes should be discussed with them in advance so they can make their wishes known and have them respected.

● Discussions with people and their families had been documented as needing to happen but these had not taken place. None of the records we viewed gave details about what the person wanted to happen to their body following their death.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to maintain relationships with the important people in their lives. We saw visitors spending time with their loved one in the privacy of the person's room. People told us they were supported to keep in contact with their families.

● People told us they enjoyed the activities which took place at the home. Staff told us there had been a guest singer the previous day. Because some people were not able to attend the performance, staff had taken a recording so people could watch this in their own room. One person said, "It was lovely singing, I would've missed it without the girls [staff] bringing the video in for me."

● The home had a cinema room where people could watch films in comfortable chairs. One person told us, "We always enjoy going to see a film. They have some really good films."

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.

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

- The deployment and oversight of staff needed significant improvement at the service. Despite enough staff being on duty, the provider had not ensured the shifts were led effectively by those who had been allocated as shift leaders.
- The culture at the service did not support people's safety, choices or the management of risk. There was a lack of accountability, responsibility and a culture of staff failing to act on known risk and report witnessed abuse which led to a failure to take appropriate action.
- Staff did not always use the training they had been given and the safe systems of work which were in place to help keep people safe at all times.
- The provider had not ensured staff understood their responsibilities so their governance arrangements could be supported. We found a lack of oversight and direction to ensure staff had the competence and understanding of what they needed to do.

Continuous learning and improving care

- The provider's audit and governance systems were not effective. The use of these systems had not always identified where improvement was needed to help mitigate risk to people's health, safety and welfare.
- Previous quality visits by the local authority and local NHS agencies had identified concerns throughout the service. The local authority confirmed the provider had made some improvements, which the provider could evidence. However, we found areas where despite the provider being aware of issues, little or no progress had been made.
- We saw areas of poor practice which the provider had already identified and taken action on which included, medicines management, safeguarding concerns and staff not wearing PPE correctly. However, despite actions being taken this poor practice continued to happen.
- The provider had failed to ensure care was well planned and risks were safely managed to meet people's needs. Although most people spoke positively about the care they received, the provider had failed to act on known issues and concerns at the service.

Working in partnership with others

- Feedback we received from community professionals did not confirm effective working relationships and did not support a safe and well-led service.
- Regular multi-disciplinary meetings were attended by the service and community professionals to help

monitor the health of people. However, community professional told us staff from The Farmstead were not prepared for these meetings which led to care being delayed. This was further compounded by the use of agency nurses who did not know people or the systems in place.

The provider had not ensured risks to people's health and wellbeing was mitigated by the systems they had in place. The provider had not ensured that the risks associated with continued poor care practice had been addressed. This is a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had recently left the service but had not yet de-registered with us. The provider was recruiting for a new registered manager.
● The provider had interim management arrangements in place and the manager who was present for our inspection had been at the service for 3 days. They were supported for our inspection by the nominated individual. The provider has appointed a new nominated individual since our inspection.
● The provider had processes in place to analyse incidents and accidents. The actions taken were recorded in response to any incidents. We saw the provider looked at incident trends on a monthly basis.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had failed to ensure duty of candour had been applied at all times. Duty of candour was understood by managers but they could not evidence how this had been applied in practice, especially in relation to complaint resolution and open and honest feedback to one family, following a safeguarding concern.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had recently given people and relatives the opportunity to provide feedback to the service though a questionnaire. The final outcome of this was not yet available. However, we saw some positive feedback from people about recent improvement within the home.
● People told us they knew a new provider had taken over the home earlier in the year and they were aware of recent management changes. After our inspection, the provider sent us evidence of the correspondence they had sent to people and their families to ensure they were kept up to date with the changes.
● The provider kept staff up to date on changes which were happening at the service, including management and leadership changes. Directors had visited the home and had spoken with staff along with the new manager.
● Staff told us they were happy with the support they received and since the new provider they had received more training. They told us staff meetings took place and were starting to become more regular. They felt they were kept updated on the changes within 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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people's rights were protected and that staff understood and followed the principles of the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12, (1)(2)(a)(b)(c)(g)(h) The provider had failed to ensure the safe management, including the storage of service user's medicines. There was a failure to protect people through infection control practices and the monitoring and management of risks. Lessons had not been learnt when things had gone wrong.

The enforcement action we took:

The provider was served with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13, (1)(2)(3) The provider had failed to ensure their systems and processes were operated effectively by staff to prevent abuse of service users.

The enforcement action we took:

The provider was served with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17, (1)(2)(a)(b)(c) The provider had failed to ensure your governance system were effective in assessing, monitoring and improving the quality and safety of the service. The provider had failed to ensure staff understood their responsibility and accountability so that their governance arrangements could be supported.

The enforcement action we took:

The provider was served with a warning notice.