Didcot Care Home Limited

Alma Barn Lodge

Inspection report

Didcot Road
Harwell
Didcot
OX11 6DN

Tel: 01235248824
Website: www.advinia.co.uk/care-homes/alma-barn-lodge

Date of inspection visit:
07 September 2023

Date of publication:
06 November 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Alma Barn Lodge is a residential care home providing accommodation for people who require nursing and personal care. The care home accommodates 85 people across 3 separate floors, each of which has separate adapted facilities. One of the wings specialises in providing nursing care to people. At the time of our inspection there were 33 people living at the home across 2 floors.

People's experience of using this service and what we found
People were not always protected from harm. Risk assessments did not always identify all known risks or contain sufficient mitigation strategies. Concerns with risk management included, risk of skin pressure damage, health concerns, and food and fluids.

There was not always sufficient staffing to meet people's needs in a timely manner. People, relatives and staff consistently told us staffing was an issue. People at times had to wait for staff support due to the deployment of staff.

Staff had not always received training in all the areas required to meet people's holistic needs. Staff did not always feel supported.

Records to evidence staff supported people in line with their assessed needs were not always in place. We found records were not kept updated for support with repositioning, support with oral care, food and fluid recording and support with personal hygiene tasks.

Systems and processes to ensure good oversight of service were not always effective or in place. Management oversight was a concern due to the number of managers the service had employed who left soon after. Action plans submitted were not reflective of the actions that were still outstanding from the previous inspection.

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.

Cleaning schedules were in place to identify the areas of the home that required regular cleaning. The main communal rooms all appeared clean. However, people told us, and we observed people's bedrooms and furnishings were not always kept clean and tidy.

People were supported by staff who had been recruited safely. The provider had made the relevant checks prior to staff working to ensure they were of good character. People told us staff were kind.

People were supported to access healthcare. Referrals had been made as required to district nurses, GPs,

speech and language therapists and occupational therapists. People received their medicines in a timely manner. Staff had the necessary training and competencies to safely administer medicines.

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 9 December 2022) and there were breaches of regulation found.

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.

At our last inspection we recommended that the provider seek advice and guidance from a reputable source, about creating a physical environment that supports the needs of people living with dementia. At this inspection we found the provider had acted on the recommendation and had made improvements.

Why we inspected
We received concerns in relation to staffing, record keeping and oversight. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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 not changed from requires improvement, based on the findings of this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to staffing, management oversight, risk mitigation, and consent from people at this inspection.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Alma Barn 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 completed by 2 inspectors and an 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
Alma Barn 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. Alma Barn Lodge 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. The registered manager had just resigned at the time inspection. An interim manager had been appointed.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. 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 used all this information to plan our inspection.

During the inspection
We spoke with 14 people who use the service and 8 relatives about their experience of the care provided. We spoke with 12 members of staff, including the manager, domestic staff, kitchen staff, nurses, and care workers. We observed staff interactions with people whilst delivering care and support in communal areas during mealtimes, medicines administration and provision of activities.

We reviewed a range of records. This included 9 people's care records, multiple medicine records and daily notes. We looked at 4 files in relation to the recruitment and supervision of staff. We examined a variety of records relating to the management of the service, including policies and procedures, quality assurance audits, and health and safety records.

Requires Improvement

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. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last inspection the provider had not consistently ensured systems were robust enough to assess and manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our last inspection we received limited assurances around the monitoring and mitigation of the risks relating to the health, safety and welfare of people and accurate, complete, and contemporaneous record keeping. This was a breach of regulation 17 (1) 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 and 17.

● People were at increased risk of skin pressure damage. At the last inspection we found concerns with the support people received in relation to repositioning. At this inspection we found gaps in people's repositioning records. Therefore, we could not be assured people received the support required to reduce the risks of skin pressure damage. For example, 1 person who required support every 4 hours with repositioning only had support recorded once per day. One person's pressure mattress had been set at the incorrect weight, which meant it would not be effective in reducing the risk of skin pressure damage. This had not been identified until we informed the manager during the inspection.
● People were at risk from known health conditions. One person had no information regarding their epilepsy, any risks associated with epilepsy and what signs and symptoms staff should be aware of to support the person safely. Staff had not received training in identifying and mitigating the risks associated with epileptic seizures.
● Not all risks had been assessed and mitigating strategies implemented. For example, when a person required 15 minutes checks to be completed to reduce known risks, these checks had not been recorded as completed. When people displayed anxiety or distress the risk assessments did not always include how the person would present, to support staff to understand the mitigating strategies required.
● People were at risk of urinary tract infections (UTI). Records did not evidence people were offered sufficient fluids daily. For example, 1 person's records stated they required 1500ml per day to reduce the risk of a UTI and because the person did not drink lot. Their records evidenced staff had only offered the person 230ml on 1 day and less than 900ml on 4 other days.
● People were at risk of malnutrition. Records did not always evidence people were offered sufficient food. For example, 1 person required all their meals to be fortified, and at least 3 snacks per day to be offered, records did not evidence this had occurred.
● The provider had reviewed safeguarding incidents. However, there were 4 incidents of people leaving the

building without staff's knowledge, 1 in May 2023, 1 in June 2023 and 2 in July 2023. Three of the incidents involved the same person, which indicated effective action and review had not been taken or learning implemented to prevent reoccurrence.
● The provider reviewed falls for trends and patterns. However, there appeared to be no analysis of unwitnessed falls to determine if staffing or the environment had impacted on these falls.

The provider had not consistently ensured systems were robust enough to assess, manage and mitigate the risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had not consistently ensured sufficient numbers of suitably trained staff were provided. This was a breach of regulation 18 (1) 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 18.

● At the last inspection we found there were not always sufficient staff deployed to ensure people's needs were met. At this inspection we found staff deployment was still a concern. The manager told us they should have 4 carers, 1 nurse and 1 senior care worker on each shift to meet the needs of the people living at Alma Barn Lodge. Rotas evidenced on 9 occasions in August 2023, there were not sufficient staff on duty.
● People told us due to the lack of staffing they often had to wait for support. One person said, "I have to wait (for staff), more often I wait for a while." Another person said, "There are too few (staff). They could do with more staff especially at night." Another person said, "When I use my call bell, I do get a response but have to wait for up to 10 minutes for someone to come."
● Staff told us they did not feel there were enough staff. One staff member said, "Some (people) do not get maximum attention and tasks are left." Another staff member told us, "Our staff levels are not good, some shifts we are fully staffed but a lot of shifts we only have 1 nurse, 1 senior and 1-2 carers (on a night shift) between 2 floors looking after 30+ people, when we are understaffed, we are not able give people any 1:1 time. (Support with) Incontinence is not able to be done on time because the carer on shift is having to work between 2 floors."
● Relatives told us due to the lack of staff they were left at the door for long periods of time and their relatives did not always have their needs met in a timely manner. One relative told us, "The number of staff is usually adequate. The staff, especially the carers, respond as best they can to all residents' needs, but rarely are they, at demanding and difficult times, able to deliver appropriate care and attention to the residents. The residents suffer as a result." Another relative told us, "You can be stood at the door waiting to be let in for up to 10 minutes (due to staff not being able to respond)."

The provider had failed to ensure sufficient numbers of suitably trained staff were deployed. This was a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found concerns with safe recruitment practices. At this inspection we found the provider had recruited staff safely. The provider requested references from previous employment and the employees' Disclosure and Barring Service (DBS) status had been checked. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

Preventing and controlling infection
At our last we saw evidence that the service was not always clean, thus we were not reassured that the service assessed the risk of and prevented the spread of infection. This was a breach of regulation 12(2) 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 continued breach of regulation 12.

● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises, or that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not fully assured that the provider was supporting people living at the service to minimise the spread of infection.
● Cleaning records were in place and completed regularly. However, we found areas of people's bedrooms were dirty and food was visible on the floor, we also found people's bedsheets were stained and required changing. One person told us, "No one changes my sheets. I have to ask and ask to have clean ones."
● People and staff told us that cleaning had improved. However, there were still some issues. One person said, "The fridges are never cleaned, carers put milk cartons in without screwing the caps properly and milk leaks over everything." Another person said, "I haven't seen my room hoovered so effectively (as today) since I have lived here. (Staff member) is the first one who has ever moved the furniture to enable a full thorough hoover of my room."

The provider had failed to ensure the service was clean, and therefore, could not be assured of preventing the spread of infection. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The home was open for visitors with no restrictions in accordance with the current guidance.

Using medicines safely
● Medicines were managed safely. Records evidenced people received their medicines as prescribed.
● People who required time sensitive medicines told us they received their medicines regularly and on time. Records also confirmed this. One person said, "I have to take medication 6 times a day. I have to be careful when I go out because some of my medicines are time sensitive and the logistics of when I get back to the home are important."
● When people required 'As required' (PRN) medicines there were protocols in place to support staff to understand the reason the medicines had been prescribed and the situations when the medicine should be given. However, the reasons for administering the medicines were not always clear. For example, staff had recorded the reason at times as "requested" with no other reason recorded.
● Staff had been trained in administering medicines and their competence regularly checked.

Systems and processes to safeguard people from the risk of abuse

● At the last inspection we found when people suffered injuries, records were not always completed to identify the size, shape, and colour of the injury or any follow up information regarding how the injury occurred, was healing or action in place to prevent the incident from reoccurring. At this inspection we found improvements had been made to the recording of injuries.

● The provider had policies and procedures in place regarding safeguarding people. Staff received safeguarding training and understood the signs of abuse and how to report any concerns. People and relatives told us they felt safe.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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
At our last inspection the provider had not ensured staff were suitably trained, supported and supervised. This was a breach of regulation 18 (2) 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 18.

● Staff had not always received appropriate training to meet the needs of the people living at Alma Barn Lodge. For example, staff had not received training in epilepsy, learning disability or managing distressed behaviours. An action plan completed by the provider after the previous inspection stated staff training (including seizure management/epilepsy) would be completed by March 2023. We found this action had not been completed at the time of inspection.
● The provider had completed an analysis of an incident, the learning included training, competencies and coaching in specific areas to be completed with staff. However, at the time of inspection these had not been completed.
● Staff told us they did not feel supported. One staff member said, "I don't feel supported, night staff never see management, and any meetings that have been done are done during the day so night staff are unable to attend because they sleep during the day. It has been mentioned previously that they need to have a meeting that night staff are able to attend they say they will organise this but it never happens." Another staff member said, "I haven't had a supervision for over 8 months."

The provider had failed to ensure staff received appropriate training and support to enable them to carry out their duties. This was a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff completed an induction and shadow shifts before completing any lone working. (Shadow shifts are when an inexperienced staff member follows and observes a trained and experienced staff member).

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 had not always ensured the service was working within the principles of the MCA and consent to people's care and treatment had always been obtained in line with law and guidance.
● Decision specific capacity assessments had not been completed. For example, we found people had 1 capacity assessment for "living in a locked care home" but no decision specific capacity assessments had been completed.
● When people's care records stated they had capacity, there was not always evidence of how this assessment had been made.
● The provider had not always ensured that people who gave consent (on behalf of others) had the power of attorney to do so. (A power of attorney is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions.) One relative told us, "[Name] has signed most of the paperwork as a power of attorney for [person's name], which obviously isn't the case. I have power of attorney for [person's name]."

The provider had failed to ensure care and treatment was provided with consent of the relevant person and to act in accordance with The Mental Capacity Act 2005. This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider or manager referred people to be assessed under DoLS. Any conditions related to DoLS authorisations were being met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
● Staff did not always have the information required to support people safely. Information was not always consistent within various care records. For example, the kitchen information for one person stated they were on a low-fat diet. However, the care plan stated the person required their food fortified.
● People's choices were not always respected. One person told us they had requested female only staff, for personal care. The person said, "I have to accept male carers if I am told there is no one else to help me. I do get annoyed sometimes when it is a man." Another person's records stated staff had given them beef for dinner when the person was a vegetarian.
● Records of support offered to people were not always consistent. For example, records to evidence if a person had a bath, shower or wash were not always in place.
● Assessment of people's needs, including those in relation to protected characteristics under the Equality Act were reflected in people's care plans.
● Although people told us the food was OK and they had choices. We observed and people told us they could be waiting for a long period between their meal and pudding. One person said, "It (pudding) will come

eventually."

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

● People's oral healthcare needs were not always recorded. Records of support with oral care for a person who required support evidenced in a period of 1 month support was only offered 4 times.

● People had hospital passports in place. Hospital passports are used by health and social care professionals to identify the support people require. When people had 'Do not attempt cardiopulmonary resuscitation' (DNAPCR) documents, these were accessible to staff.

● Staff worked with external professionals to ensure people were supported to access health services and had their health care needs met. We saw evidence of referrals being made to district nurses, occupational therapists and speech and language therapists.

● People had regular access to GPs, and staff sought advice when needed. Staff supported to people to visit the dentist or optician if required.

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

● There were a number of communal areas around the home including lounges, a cinema room. Hair salon and multiple dining rooms where people could spend their time.

● People's rooms were personalised to their needs and wishes.

Requires Improvement

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. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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
At our last inspection the provider had failed to ensure there were effective governance and quality assurance measures in place. This was a breach of regulation 17 (1) of the health and Social Care Act 2008 (Regulated Activities) Regulations 14.

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

- The provider completed an action plan following the last inspection. The action plan stated by the end of March 2023 they would: obtain accurate reports and information from the call bell system, complete ongoing and consistent auditing and oversight of evidence and recording and complete an appraisal and supervision structure to monitor knowledge, skills and development of the staff team. At this inspection we found these had not been completed. Concerns are recorded within the safe and effective domain in this report.
- Systems and processes had failed to identify and mitigate risks when insufficient trained staff were deployed and the effect this had on people living at Alma Barn Lodge. This put people at risk of not having their needs met. Concerns are recorded within the safe and effective domains in this report.
- Systems and processes were ineffective in identifying when records were not kept up to date. This put people at risk of skin pressure damage, dental issues, hygiene issues, dehydration and malnutrition. Concerns are recorded within the safe and effective domains in this report.
- Systems and processes were ineffective in mitigating risks associated with incorrect, conflicting, or missing information being recorded. This put people at risk of maintaining their own safety, distress, and anxiety, having their needs and preferences met. Concerns are recorded within the safe and effective domains in this report.
- Systems and processes were ineffective in ensuring the environment was kept clean and people had clean bedding. Concerns are recorded within the safe domain in this report.
- Systems and processes were ineffective in identifying and implementing strategies to reduce any risks associated with medicine management. We found thickener was not always recorded as given and the reasons for PRN medicine use had at times been recorded as "requested" with no further information regarding the reason. This put people at risk of aspiration and not receiving medicines as prescribed.

Concerns are recorded within the safe domain in this report.

● Systems and processes were not in place to ensure compliance with the Mental Capacity Act. This put people at risk of not receiving care in line with their best interests. Concerns are recorded within the effective domain in this report.

● Systems and processes had failed to identify when specific incidents required a full investigation to learn lessons and prevent reoccurrence. Concerns are recorded within the safe domain in this report.

● Staff raised concerns with the inconsistency in management support. The service has had multiple managers who only stayed for a few months before leaving the service. One staff member said, "We have limited support as we have already had 8 different managers. We go 1 step forward but then 3 steps back." Staff felt the inconsistency of having stable management was detrimental to people's experiences living at Alma Barn Lodge.

● People told us due to the lack of staff; they did not receive the attention or support they needed. A staff member told us, "In the morning we need more staff to give people time, otherwise it is hello, how are you, next please. Of course we manage, but we do not have time to spend and chat with people." During the inspection we observed people not being interacted with which was detrimental to their wellbeing. One person told us, "No one has spoken like this with me before (relating to inspection team) they (staff) don't bring it out of us much here. I haven't spoken like this for ages." Another person told us, "I feel like I have just lost everything, so many things don't work anymore, and I don't know why."

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us currently they would not recommend Alma Barn Lodge. The concerns were linked to staffing and management changes. However, 2 people told us they would recommend Alma Barn Lodge due to staff being kind. However, they also raised concerns with staffing and management changes.

● The provider implemented new systems and processes based on the feedback given following the inspection. However, as these systems and processes were not in place at the time of inspection we could not assess their effectiveness.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had systems in place to take account of staff, relatives and people's opinions of the service. The provider requested feedback from people, relatives and staff through a survey. However, at the time of inspection there was no analysis of responses or action plan in place to mitigate the concerns shared. There was also a lack of evidence showing feedback was collated and used to improve the service.

● Regular meetings with staff, relatives and people had recently been implemented. However, people told us they did not feel listened to. One person said, "Nothing gets better, nothing changes and the only responses you get are "we are looking into it" I find that discouraging." A relative told us, "Meetings are few and far between, so not really helpful."

● We received mixed views on whether people and relatives were involved in care planning or if they had seen a copy of the care plan. A person told us, "I am aware I have a care plan, it is discussed with me." However, 9 other people we spoke to said they were not involved and did not know where their care plan was kept. One relative said, "I was involved (in care plan) but I have still not seen a copy." Another relative said, "I haven't seen the care plan for a long time. I have asked to go through it and update it, but this still hasn't happened."

● Relatives told us the staff did not always keep them up to date on any changes, incidents or accidents relating to their loved one.

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 manager was aware of their role and responsibilities about meeting CQC registration requirements including submitting statutory notifications about the occurrence of any key safeguarding events or incidents involving people they supported. Notifications had been submitted.
- The manager was aware of their duty of candour responsibility and had systems in place to ensure compliance.
- Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

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 care and treatment was provided with consent of the relevant person and to act in accordance with 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 The provider had failed to ensure the service was clean, and therefore, could not be assured of preventing the spread of infection. The provider had not consistently ensured systems were robust enough to assess and manage the risks relating to the health safety and welfare of people

The enforcement action we took:

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 The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably trained staff were deployed. The provider had failed to ensure staff received appropriate training and support to enable them to carry out their duties.

The enforcement action we took:

Warning Notice.