A Bright Care Ltd

Barham House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Barham House Nursing Home 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. Barham House Nursing Home is registered to provide accommodation, nursing and personal care for up to 23 older people in one adapted building. There were 17 people using the service at the time of our inspection.

People's experience of using this service and what we found
People continued to be at risk of serious harm at Barham House Nursing Home.

There continued to be a lack of leadership and oversight at the service. Again, this had impacted on all areas of people's care and treatment. The provider and manager had not developed an open and honest culture, centred around the people's needs and wishes. They did not have the required oversight of the service and poor and unsafe practice continued unchallenged.

The provider had not acted to ensure all areas of the service were clean and free from the risk of infection. Covid-19 tests were not completed on visitors and staff. Robust arrangements had not been put in place to ensure all areas of the building were clean to minimise the risk of infection.

Effective action had not been taken to assess and review risks to people. People's care and support had not been planned to mitigate risks and keep them as safe as possible. Detailed guidance had not been provided to staff about how to keep each people safe and well. There were not always enough staff on duty to meet people's needs and protect them from harm.

Staff continued not to be recruited safely. The provider had taken very little action to protect people from unsuitable staff since our last inspection. Checks had not been completed on new staff. No further checks had been completed on senior staff's character and conduct in previous roles. Concerns from the Disclosure and Barring service had not assessed to ensure staff were safe to work with vulnerable people. Staff did not have the skills they needed to keep people safe and respond in an emergency.

People's medicines were not managed safely. People did not always receive the medicine they needed. Guidance was not in place to administer emergency medicines. Other medicines were not administered as prescribed.

People were not protected from the risk of abuse. Safeguarding concerns had not been shared with the provider or the local authority safeguarding team.

People, their relatives and visiting professionals had not been asked for their experiences of the service to drive improvement. Robust checks and audits had not been completed to understand the quality of the

service and shortfalls we found had not been identified. Action had not been taken since our last inspection to address the poor quality care people received.

Records of the care people received were not accurate and complete. Some confidential information about people was not disposed of securely.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 12 March 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. We completed a targeted inspection of the service on 27 January 2021. We did not review the rating for the service as part of this inspection. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
Our previous inspection found shortfalls at the service in relation to infection control and prevention, the management of risks to people, staff recruitment and staff compliance and leadership and oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. 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 requires improvement to inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection prevention and control, risk management, staff recruitment, checks and audits and governance and leadership, safeguarding people from abuse, medicines management and the completeness of records at this inspection.

We took action against the provider and cancelled their registration. Everyone moved out of the service and the service is now closed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Barham House Nursing 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
This inspection was completed by four inspectors. Three inspectors visited the service and another inspector reviewed information off site.

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

The service does not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with six members of staff including the nominated individual, manager, senior nurse and care workers. 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 nine people's care records, four staff files in relation to recruitment and medication records for everyone. We also reviewed a variety of records relating to infection prevention and control.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and processes the provider had in place.

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 inspection on 16 and 21 January 2020 this key question was rated as requires improvement. We did not review the rating as part of our targeted inspection on 27 January 2021. 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
At our last two inspections the provider had failed to consistently assess, identify and monitor risk to people's health, safety and welfare. This was a breach of regulation 12 (Safe Care and Treatment) 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.

- People continued to be at risk of harm. We observed one person using a wheelchair with the assistance of staff. The person was not using footplates and this increased their risk of damaging their feet and ankles. Staff told us this was the person's choice. The risks of injury to the person had not been fully assessed and safe care had not been planned to mitigate the risks. Moving and handling assessments were not individualised and did not describe techniques to move each person safely. Since our last inspection the provider had ordered new hoist slings. These had arrived but were not in use.
- People continued to be at risk of choking. Care plans had been updated to include general guidance around first aid when someone choked. However, these were not specific to people's individual needs. For example, how to support someone who was in bed or in a wheelchair. There was a continued risk people would not receive the care they needed if they choked.
- People continued to be at risk of falling. Risks to people had not been robustly assessed and care had not been planned and delivered to mitigate risks. One person fell regularly, and falls were unwitnessed. They had tried to climb over the bedrails several times. A senior nurse told us staff continued to use the person's bedrails despite being instructed not to, and this increased the risk of injury. An alert mat was in place to tell staff when the person was at risk. The manager told us this was not effective but had not acted to ensure staff were aware when the person was at risk. Lessons had not been learnt when accidents or incidents occurred. Action had not been taken to reduce the risk of them occurring again. Incidents, such as a person opening the stair safety gate had not been reviewed and the person's care had not been changed.
- Assessments of bedrails had been reviewed since our last inspection. However, risks associated with their use had not been identified and mitigated. Bedrail covers had been ordered and delivered. However, covers had not been fitted to everyone's bedrails and the risks of injury continued. One person continued to have a bedrail on one side of their bed only, placing them at risk of becoming trapped between the bed and the wall. Action had not been taken to follow recognised guidance from the Medicines & Healthcare Products Regulatory Agency around the management and safe use of bedrails.
- People continued to be at risk of developing pressure ulcers. Some guidance had been given to staff about how to reduce the risks to people, including how often to support them to change their position. This

guidance had not been followed consistently to keep people safe. Some people used pressure mattresses on their beds to protect their skin. There continued to be no information about how to ensure mattresses were working correctly.
● One person continued to be at risk because care and treatment was not provided safely to manage their diabetes. Further guidance around their use of insulin, prescribed to manage their blood sugar levels, had not been requested following our last inspection. A senior nurse told us the person's diabetic nurse had provided written instructions about the person's care including when not to administer insulin. However, they were not able to show us this instruction and it had not been included in the person's care plan.

The provider had failed to operate effective processes to assess risks to people's health and safety and mitigate risks. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New weighing equipment had been purchased since our last inspection. Staff had weighed everybody once. When people chose not to be weighed staff followed recognised guidance to understand if they were at risk of malnutrition.

Preventing and controlling infection
At our last inspection the provider had failed to robustly assess the risk of the spread of infections and act to prevent and control the spread of infections. This was a breach of regulation 12 (Safe Care and Treatment) 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.
● People remained at from the risk of infection, including Covid-19. One staff member held the lead responsibility for Infection Prevention Control (IPC). The manager told us the lead staff member was responsible for, "IPC procedures, monitoring infections and updating staff on IPC measures". The staff member had not completed training in relation to their role since our last inspection and no training had been arranged. Staff had completed online IPC training following our last inspection. However, their competence to complete safe IPC processes, such as hand washing had not been assessed.
● Following our last inspection, we required the provider to put a cleaning schedule into operation. The provider had failed to develop and implement a robust schedule which covered all areas of the building and the frequency of cleaning. The sluice, laundry and medication rooms were all visibly dirty and this increased the risk of infection spreading. Records of cleaning undertaken were not complete and we could not be assured all areas of the service had been cleaned regularly.
● Action had not been taken following our last inspection to protect people from the risks of infection being brought into the service by visitors. Visiting contractors had not been required to follow the provider's visitor procedures, including wearing surgical masks. Their temperature had not been taken and recorded on entry. We observed contractors entering and leaving the service without using the hand sanitiser provided.
● Effective action not been taken to comply with Covid-19 social distancing guidance. Staff did not encourage people to maintain a social distance. People continued to share bedrooms despite single occupancy rooms being vacant. Staff did not maintain a social distancing in the office, which was used by all staff and the provider.
● The provider had not followed UK government guidance in relation to testing for Covid-19 in care homes. One person had not been tested for Covid-19 following a period of isolation after a hospital stay. The provider was not using lateral flow tests to check if staff and visitors had Covid-19 before they entered the building. Lateral flow tests were available on site, but staff did not have the skills to complete them.

The provider had failed to robustly assess the risk of the spread of infections and act to prevent and control the spread of infections. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to establish and operate effective recruitment procedures to ensure staff were of good character and had the qualifications, competence, skills and experience necessary for the role. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) 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 19.
● People continued to be at risk from staff who had not been recruited safely. Since our last inspection the provider had not taken robust action to ensure they had all the information they required to review previous recruitment decisions. They had not obtained a full employment history, with the reasons for leaving from existing staff. Again, gaps in staff's employment history had not been identified and explored.
● References had not been requested for staff where they had not been previously obtained. The provider began to do this after this inspection. Disclosure and Barring Service (DBS) checks had been requested for existing staff. However, no action had been taken to understand and risk assess disclosures on one staff members DBS check to ensure they did not pose a risk to people.
● Since our last inspection the provider had employed two new staff. No recruitment records had been maintained in relation one new staff member. Robust recruitment checks had been completed to ensure the second staff member was safe to work with vulnerable people.

The provider had failed to establish and operate effective recruitment procedures to ensure staff were of good character and had the qualifications, competence, skills and experience necessary for the role. This placed people at risk of harm. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not always enough staff on duty to meet people's needs and keep them safe. The provider had assessed two carers and one nurse were required to provide people's care and treatment at night. The local fire and rescue service required there were additional staff sleeping on site to ensure a timely evacuation in an emergency. On 10 February 2021 only one member of care staff worked the night shift. No nurses were on shift. One nurse had slept in the building. At least nine people required two staff to support them to change their position during the night. There were no records to confirm position changes had been maintained. There were insufficient staff at the service to keep people safe in the event of a fire. This placed people at risk of significant harm.
● One person was at high risk of falling and the manager told us they required constant supervision at times to reduce this risk. They had identified additional staff were required to provide this level of support but had not deployed staff to complete this task. They told us there was a staff member in the lounge, "most of the time" to supervise the person. However, we noted several occasions when there were no staff in the lounge and the person was at risk of falling. The day after our inspection the person had an unwitnessed fall in the lounge which required checks in hospital. We observed another person take their top off in the lounge and reveal their underwear. Staff did not notice this and only acted when inspectors prompted them to maintain the person's dignity.
● Nurses' competence to complete basic nursing tasks, such as medicine administration, using a percutaneous endoscopic gastrostomy (PEG) to assist people to eat and drink and managing urinary catheters had not been assessed. Nurses had not been trained to administer an emergency medication

prescribed for one person.
● There were several nurse vacancies and the provider relied on agency nurses to meet people's clinical and treatment needs. One nurse left following our inspection and only one night nurse remained employed by the provider. Agency nurses did not know people well and relied on information in people's care plans to meet their care and treatment needs. This increased the risk that people would not receive the care and treatment they needed.
● Since our last inspection staff had completed refresher training in moving and handling. However, this training had not been effective, and we observed poor moving and handling practice. We observed four staff move one person from their bed to an armchair as their pressure mattress had failed. The manoeuvre was not planned, and staff left the person dangling in the hoist above their bed for several minutes.

The provider had failed to ensure suitably competent, skilled and experienced staff were deployed to provide care and treatment. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse. During our last inspection, a staff member raised safeguarding concerns with us. They had not been confident to raise these with the provider and did not know how to blow the whistle outside of the service. We shared the concerns with the local authority safeguarding team for their investigation.
● On 10 February 2021 no one received their 9 pm medication. A nurse was in the building but had gone off shift. They did not tell the manager or provider people had not received their medicines. The manager noted the missed medicines on 12 February 2021 but did not inform the provider or people's GP. People were not monitored for any adverse effects of missing these medicines and there was a risk their health, and welfare needs would not be met. The manager did not contact the local authority safeguarding team until after we had asked them if they had raised a safeguarding alert.

The provider had failed to ensure service users were protected from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicines were not managed safely, and they were at risk of harm. One person was prescribed emergency medicine to be administered if they had a seizure. No guidance had been provided to staff about the medicine and when it was to be administered. The manager was not confident nurses had the skills required to administer the medicine safely. There was a risk the person would not receive their medicine when they needed it.
● There was a risk one person would be given their medication without their knowledge, known as covert administration. Information on the person's medication administration records stated they were reluctant to take their medication at times and staff were to put it in food or yogurt. The provider's policy for covert medication had not been followed and action had not been taken to ensure the medicine was given safely and in their best interests. There was a risk the medicines would not be effective.
● One person's insulin had not been given as prescribed and this placed them at risk of harm. The morning dose had not been given on eight occasions since our last inspection. Records of the person's blood sugar levels were very high on days they had not had their morning insulin. On occasions the person refused to have their blood sugars checked during the day and insulin had not been given. Staff had contacted the GP to review the person's diabetic care on 2 February 2021 and were advised to complete a blood test. There is no evidence this was completed.

● Records in relation to medicines were not robust. Handwritten entries had not always been checked and counter signed to confirm they were accurate. Clear explanations had not been recorded when people had not had their medicine, despite codes for this being detailed on all the medication administration records.
● At our last inspection we found guidance had not been put in place for staff about the administration of prescribed creams. No action had been taken to provide staff with this information. Care staff told us they applied creams based on some knowledge of the person. However, creams were not always used as prescribed. One person was prescribed an emollient cream to be used instead of soap. Staff told us they used soap to wash the person and applied the cream afterwards. This left the person at risk of skin damage.

The provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 full inspection on 16 and 21 January 2020 this key question was rated as requires improvement. We did not review the rating as part of our targeted inspection on 27 January 2021. 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.

Continuous learning and improving care
At our last inspection the provider had failed to ensure the systems in place to regularly assess and monitor the quality and safety of the service were effective. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Following our inspection of 27 January 2021, we imposed conditions on the provider's registration for Barham House Nursing Home. These were to ensure they took urgent action to address serious shortfalls in infection prevention and control processes, including managing Covid-19 risks. Robust action had not been taken and risks to people continued.
● The provider had not ensured mental capacity assessments had been completed in line with the Mental Capacity Act 2005 following our January 2020 inspection. When staff thought people may need support to make important decisions, they had not assessed their capacity to make the decision. The provider had failed to exercise appropriate oversight to ensure concerns previously pointed out to them were addressed.
● The provider continued to rely on the manager to assess and review the quality of the care people received. Checks completed by the provider focussed on the fabric of the home and ongoing building works. The provider had not assured themselves of the integrity and effectiveness of checks completed by the manager and neither were aware of the shortfalls we found. For example, inadequate risk assessments which put people at continued risk of harm as their complex care and nursing needs were not clearly recorded or met.
● Previously we found the provider had not acted to obtain information they needed about senior staff following an audit of staff recruitment files. Very little action had been taken following our inspection to obtain important information required by law.
● The provider had an improvement plan in place. This reflected the failings and concerns pointed out at this and the previous inspection. Tasks had been allocated to senior staff but specific dates for completion had not always been recorded. There was a risk some actions would not be included in reviews of the plan. Some areas of improvement relied on staff training. Where training had been delivered, checks on staff competency had not been completed to ensure the training was effective. Plans were not in place to review the improvement plan.

The provider had failed to operate effective systems regularly assess and monitor the quality and safety of the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Again, we found the provider had not ensured staff knew their responsibilities and were held accountable for their actions. This had been pointed out to the provider at our last inspection. No action had been taken before our inspection in relation to the nurse who had not given people their medication on 10 February 2021. We found nurses had changed one person's catheter on several occasions. The provider was not commissioned by the local clinical commissioning group (CCG) to provide nursing care to the person and any nursing care should have been provided by community nurses. The nurses had acted outside of their professional code of conduct by providing nursing care to the person.

● People's care plans continued to lack detail and guidance for staff about the care people required. This had been pointed out to the provider at our last inspection. Although some care plans had been updated, guidance was not specific to the person or complete. For example, two care plans lacked guidance about the management of diabetes and use of emergency medicines prescribed to control seizures. This presented a risk of unsafe care.

● Records continued to be inaccurate or incomplete and this placed people at risk of harm. Staff had not been trained to use the electronic care planning system since our last inspection. There continued to be gaps in people's care records. Other records were not completed at the time care was provided or incidents occurred. Staff signed into the system as each other and records showed they had been completed by staff who were not in the building. Cleaning completed had not been recorded on several occasions. The manager told us the current recording system was "not user friendly". However, they had not acted to change the way completed cleaning was recorded.

● Information about people was not kept safe and secure. A senior nurse told us packaging for people's medicines was disposed of with the household waste. Medicines packaging contained confidential information about people and should have been disposed of as confidential waste.

The provider had failed to establish effectively operated systems or processes to monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had failed to securely maintain an accurate and complete record in respect of each service user care and treatment and monitor and mitigate the risks. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to promptly inform us of important events that happen in the service. This is so we can check appropriate action had been taken. The provider had failed to notify us of the death of a service user in December 2020.

● The provider had also failed to inform us of an occasion when, overnight, there was only one member of staff and no registered nurse on duty and people had not received their medication. They had also failed to notify us when hot water had not been available to people and staff because of a boiler malfunction.

The provider had failed to notify the Care Quality Commission of the death of a service user. This was a breach of regulation 16 (Notification of death of a service user) of the Care Quality Commission (Registration) Regulations 2009

The provider had failed to notify the Care Quality Commission of an insufficient number of suitably qualified,

skilled and experienced persons being deployed to provide the service and an interruption in the supply of hot water at premises for longer than a continuous period of 24 hours. This was a breach of Regulation 18 of the CQC (Registration Regulations 2009) (Notifications of other incidents).

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

● During this inspection we identified an occasion where there was no nurse on duty. This resulted in people not being offered or receiving prescribed medicines or when required medicines, such as paracetamol for pain relief. On this occasion there was also a reduction in the number of care staff on duty and people had not been offered support with their personal care. The provider was not informed of this occurrence at the time and, when informed, did not apologise to people and their relatives.

The provider had failed to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There remained a lack of clear leadership and direction at the service. The provider had not acted to understand what good care looked like. They had not communicated the aims of the service and their philosophy of care to staff and the staff team did not have a shared vision for the service.

● The provider's policy to complete annual satisfaction surveys with people, their representatives and visiting professionals had not been followed. The provider told us they planned to complete the surveys by "the end of the financial year". People and their relatives had not had the opportunity to share their views and experiences of the service so they could be acted on to make improvements. Relatives we spoke with during and after our last inspection raised concerns about a lack of communication from staff about their relative's care and treatment needs. This included not being informed their relative was at their end of their life so they could visit the person and spend time with them.

The provider has failed to seek and act on feedback from service users and their relatives on the services they receive, for the purposes of continually evaluating and improving the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff surveys were completed in January 2021 and the manager was collating the responses. Their initial findings showed staff dissatisfaction about a lack of supervision and appraisal. In response, supervisions had been planned and six had been completed.

● Staff told us the manager was "approachable, compassionate and helpful" and they were confident to raise concerns with her.

Working in partnership with others

● The provider could not demonstrate they consistently worked in partnership with health care professionals. They had failed to implement a local scheme to ensure the safe and effective transition of care between the service and hospital. The equipment and document templates were at the service but had not been used when people had been admitted to hospital.

● The manager had begun to work with other health care professionals. A clinical nurse specialist from the local health trust had been working with the service since December 2020 to offer support and guidance to improve the service. The provider was acting on the requirements of the local fire and rescue service to

improve fire safety at the service.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had failed to notify the Care Quality Commission of the death of a service user.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission of an insufficient number of suitably qualified, skilled and experienced persons being deployed to provide the service and an interruption in the supply of hot water at premises for longer than a continuous period of 24 hours.

The enforcement action we took:

We cancelled the provider's registration.

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 robustly assess the risk of the spread of infections and act to prevent and control the spread of infections. The provider had failed to operate effective processes to assess risks to people's health and safety and mitigate risks. The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

We cancelled the provider's registration.

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 The provider had failed to ensure service users were protected from abuse.

The enforcement action we took:

We cancelled the provider's registration.

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 operate effective systems regularly assess and monitor the quality and safety of the service. The provider had failed to establish effectively operated systems or processes to monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had failed to securely maintain an accurate and complete record in respect of each service user care and treatment and monitor and mitigate the risks.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to establish and operate effective recruitment procedures to ensure staff were of good character and had the qualifications, competence, skills and experience necessary for the role. This placed people at risk of harm.

The enforcement action we took:

We cancelled the provider's registration.

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 suitably competent, skilled and experienced staff were deployed to provide care and treatment.

The enforcement action we took:

We cancelled the provider's registration.