Alliance Care (Dales Homes) Limited

The Branksome Care Home

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

Summary of findings

Overall summary

About the service
The Branksome care Home is a residential care home providing accommodation, nursing and personal care to up to 34 people. The service is registered to support older people and younger adults. At the time of our inspection, there were 29 people using the service.

People's experience of using this service and what we found
There were widespread safety concerns that left people at risk of harm. We found people had unexplained injuries that had not been reviewed, investigated or referred to safeguarding professionals. People were at risk of choking as they were not always supported to eat safely. Staff did not always know the risks to people's safety. People's medicines were not always safely managed, records showed people did not always have their prescribed creams applied. Staff were not always safely recruited. There were enough staff on duty. Infection prevention measures were in place to protect people from the spread of COVID-19, however staff did not always wear face masks which left people at risk of contracting viruses.

The provider had not ensured they maintained oversight of the running of the home. They had not implemented improvements required since their last inspection. Governance and audit systems were not effective at identifying and reducing risks to people's safety. When things had gone wrong the manager had not always made sure they were open and honest with people, relatives and professionals. Staff felt they were happier and more supported in their role since the last inspection.

People were not always supported to drink enough to prevent the risk of dehydration. People's food and fluid records were not routinely reviewed. Staff did not always complete training to know how to support people safely. Healthcare professional advice for monitoring people's health conditions was not always followed.

When complaints were received from relatives they were not used to recognise where improvements were required. There were activities for people to take part in the communal areas of the home but people who preferred to spend time in their bedrooms were not always offered meaningful activities and were therefore at risk of social isolation.

People's privacy was not always respected as their personal care records were sometimes stored in communal corridors. People and relatives told us staff were mainly kind and caring. People were supported to maintain and develop their independence.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 inadequate (published December 2021).The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Branksome Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safety, safeguarding, nutrition and hydration, handling complaints, governance and openness with people when something has gone wrong. 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service therefore remains 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.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

The Branksome Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by three 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
The Branksome Care Home 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 Branksome Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The provider is legally responsible for how the service is run and for the quality and safety of the care provided. The manager in post had applied to register with CQC and their application was being assessed.

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, this included from relatives and external professionals.

During the inspection
We reviewed 14 people's care records, multiple people's medicine records. We spoke with six people and 11 relatives about their experiences of care. We spoke with 16 members of staff including care staff, nurses, the manager, deputy manager, managing director and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed governance records and other records relating to the running of the home.

After the inspection
We continued to review information we had gathered. We reviewed staff training records. We discussed our findings with the nominated individual and managing director.

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

At our last inspection the provider had failed to ensure people received safe care and treatment. This was a continued 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.

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

- People were not always safe and protected from known risks of harm.
- We saw people at risk of choking were left alone with their food. This was against their health care professional guidance which stated they should be fully supported to eat and drink. Staff on duty did not always know which people were at risk of choking.
- Risk assessments were not always clear or easily accessible to staff. Risk assessments were stored in people's care plans that were inside an office in the nurse's office on the first floor. Staff supporting people on the first floor would not be able to leave people to review their risk assessments.
- Risk assessments were not always reflective of people's needs. One person was at risk of choking due to difficulty in swallowing. Their risk assessment did not include this information, this meant their risk scoring for choking was recorded as medium, when in fact they were at high risk of choking.
- People were not always protected from the risk of sore skin. We saw four people at risk of pressure sores whose pressure relieving mattresses were incorrectly set.
- There was no effective process for staff to report when people had signs of injury or potential injury on their skin. This meant people were at risk of, and some experienced unexplained injuries.
- Some relatives told us they did not feel their relation was safe. One relative said, "They give [Name] food that is not safe for them to eat, [Name] needs monitoring and it just doesn't happen." A different relative said, "The last couple of weeks have been a concern, staff have moved the call bell out of [Name's] reach and not put the thickener in their drink."
- People's care plans contained duplicated and historic information. This made it difficult for staff to know how to support people safely.
- People's weights were not always effectively monitored. We saw people had differing recordings of their weights in different folders. This meant people were at risk of weight loss that was not safely reviewed.

Using medicines safely

- Medicines were not always safely managed. People did not always receive their medicines as prescribed which meant they were at risk of harm.

● One person was prescribed a 'PRN' controlled drug as pain relief (this means they took this medicine as and when required). There was none of this medicine in stock in the home. This meant this person was at risk of not receiving their prescribed medicine and at risk of being in unnecessary pain.
● When people were prescribed PRN medicines there were not always protocols in place to guide staff how and when people should take these medicines. This meant people were at risk of not receiving their medicines as prescribed.
● Where people were prescribed medicine creams, the application of these were not always appropriately recorded. Two people who received medicine creams had gaps in the recording of these, records did not always confirm the two people had received these medicines as prescribed. In addition this had not been identified in medicine audits or review.
● Some people's medicine creams had guidance of, 'apply after every third wash'. There was no record of when every third wash was so staff did not always know when to apply these creams.

The provider had failed to ensure people always received safe care and treatment. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse.
● People's care records contained documents showing staff had noticed bruising, skin tears and other marks on people's skin. These injuries had not been reviewed, investigated, discussed with the person and their relative or referred to the local safeguarding team for independent review.
● During the inspection we raised this with the manager. Immediately after the inspection the manager sent us evidence of having inputted the unexplained injuries onto the providers recording system. However, when prompted by the system to detail whether these incidents were discussed with people, relatives or referred to safeguarding professionals, the manager had documented that this was not required due to the injuries being old. This meant the manager had failed to recognise these incidents were signs of potential abuse.
● Immediately after this inspection, we referred 16 incidents of potential abuse to the local authority safeguarding team. These included unexplained injuries and people at risk of dehydration. These had not previously been referred to the safeguarding team, even when raised during this inspection.

The provider had not implemented or operated effective systems to identify and respond appropriately to concerns of abuse. 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

At our last inspection the provider had failed to ensure staff were always safely recruited. 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.

Staffing and recruitment

● Staff were not always safely recruited. This meant there was a risk of staff working at the service without the appropriate skills and experience.
● The provider had not always ensured they had gathered enough information about staff prior to employing them. They had not always explored staff members employment history and did not always have evidence that staff had been interviewed. Where staff required 'right to work in the UK' documents, these were not clearly recorded.

The provider did not always follow safe recruitment practices. This was a continued breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had ensured all staff were subject to criminal records checks before they were employed.
● There were enough staff on duty during this inspection. People told us they felt there were enough staff. However, some relatives said they felt there were not always enough staff on duty at night and felt their relations had to wait for care.

Preventing and controlling infection
● We were not always assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. We saw multiple times when staff were not wearing face masks or had masks on that were not covering their mouth and nose. This meant people were exposed to the risk of contracting viruses such as COVID-19.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● The provider was facilitating safe visits for people. They had developed processes with regard to the government guidance. People who wanted to were able to allocate their friends or relatives to have Essential Care Giver Status (this meant visits would not be prevented during an outbreak of COVID-19 as long as the visitor completed testing).

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

At the last inspection the provider had failed to ensure people's nutrition and hydration needs were always met. This was a breach of regulation 14 (Nutrition and Hydration) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 14.

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

- People were not supported to drink enough to protect them from the risk of dehydration.
- We saw numerous records that showed people had not drunk enough to keep them healthy. These records had not been reviewed and nothing was done to ensure people were supported to drink more.
- One relative said, "[Name] is supposed to have fortified drinks but they don't get them."
- We observed a mealtime and saw a person sit for an hour with food in front of them they were unable to eat because they did not have their false teeth.
- One person and three relatives expressed concern about the food and drink. One person said, "Food isn't great here and it's not getting any better." One relatives said, "[Staff] give [Name] food they shouldn't have." A different relative said, "The food is poor."
- People did not always have choice and control over what they ate. During the inspection we were told by staff that menus were designed by a central head office rather than designed by staff who knew people's personal preferences.

The provider had failed to ensure people's nutrition and hydration needs were always met. This was a continued breach of regulation 14 (Nutrition and Hydration) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to always follow healthcare professional advice. This was a continued 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.

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

● People were not always supported to follow healthcare professional advice to keep them safe from harm.
● Three people had received advice from healthcare professionals about ongoing monitoring of their care that had not been followed.
● Where people's healthcare needs were monitored, this was not always done effectively. There was no review or action taken when people displayed certain symptoms. For example, one person was recorded as not having had their bowels opened for prolonged periods of time. This had not been reviewed or referred to a healthcare professional. This left this person at risk of pain and deteriorating health.
● People's needs in relation to oral care were not always assessed. Records showed there were large gaps in recording of people being supported with oral care. This meant it was not clear if people had been supported or not and people may have been at risk of oral ill health.

The provider had failed to ensure people were always supported to follow healthcare professional advice. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider had not always supported staff to complete training to carry out their role. Staff did not always have the skills and competence to recognise poor practice.
● We saw some staff supporting people to eat and drink who had not undertaken training to know how to do this safely. This placed people at risk of harm.
● Only 13 of the 44 staff had completed training to know how to support people to evacuate the building in an emergency situation such as a fire. This meant the provider could not be confident that staff would know how to respond in a time critical emergency situation.
● Some staff who had worked at the home for more than 6 months (and were therefore not within their induction period) had not completed training in moving and handling, infection prevention and control, dementia care or moving and handling. They did support people with these needs.

The provider had failed to ensure they supported staff to undergo training to know how to support people effectively. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People's ability to make decision for themselves was assessed. Staff were aware when people lacked

capacity to make certain decisions.
● There were documents to demonstrate that decisions made on behalf of people were made in their best interest. However, these documents did not clearly demonstrate that people and their relatives or representatives had been involved in this decision.

Adapting service, design, decoration to meet people's needs
● There were not enough adapted bathrooms to ensure people could bathe as often as they chose. There was only one adapted bath and two wet rooms. This meant it would not be possible for every person with mobility support needs to bathe as often as they may have wished. Staff told us people could only bathe twice a week.
● The environment was presented in a way that was homely and welcoming.
● People's bedrooms were personalised with their own belongings and ornaments.
● There was a choice of communal areas for people to spend their time and outside space for those who chose to use it.

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 requires improvement. At this inspection the rating has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The majority of the staff were kind and caring with people however, we saw some interactions that were not. During a mealtime we saw a staff member walk up behind a person and try to move them in their seat to sit up straight. They had not warned the person they were going to do this, the person appeared shocked and upset. The staff member did not apologise to the person.
- We received mixed feedback from people, one person said, "Staff need to buck their ideas up." A different person said, "The staff are ever so nice here."
- There was information about people's individual needs and preferences, including any cultural requirements in their care plans. However, as staff did not have easy access to care plans and the documents were not presented in a way that was easy to follow it was not clear how staff could support people to always follow their cultural beliefs.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity were not always respected.
- People's daily care records were found in corridors. These included personal information such as people's moving and handling support needs and bowel movement monitoring forms. This meant the provider had failed to keep this information stored securely.
- During a mealtime we saw care staff supporting people to take their medicines. Staff were telling people what each medicine was for in a busy room in front of other people. They did not ask people if they were comfortable discussing this in front of other people first.
- Some people were supported to be independent. We saw staff encourage people to walk rather than use mobility aids in the first instance. Some people went out of the home and spent time with friends and relatives. One relative told us they enjoyed a day out with their relation over the Christmas period.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to make decisions about their care.
- People had access to independent advocacy. Staff were aware when people's relatives held Lasting Power of Attorney (LPA) meaning they should always be consulted when decisions were made.

Inadequate

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 requires improvement. At this inspection the rating deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs. .

Improving care quality in response to complaints or concerns

- Complaints were not always dealt with in an open or timely manner.
- One person had raised a serious complaint and included video evidence of their relation in an unsafe situation. The manager had responded to the complaint without offering an apology or assurances of immediate action to keep the person safe from harm.
- The initial complaint response stated that an investigation would be carried out within four weeks. When the investigation was completed the relative was offered assurances of a newly implemented system to keep people safe from the risk of harm that was evident in the video. However, when we completed the inspection eight weeks after the initial complaint, this system had not been implemented and this person was still at serious risk of harm.
- Three relatives told us they had repeatedly raised complaints about their relations care and not felt they had been listened to. All three of these relatives told us they were now looking for an alternative home for their relation. One relative said, "I have made lots of complaints and I am not happy with the responses, I am looking for another home." A different relative said, "Nothing has improved since I first made a complaint, sometimes I email and don't get a reply."

The provider had failed to ensure they took proportionate action in response to failures identified by complaints. This was a breach of regulation 16 (Receiving and Acting on Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

After the inspection the managing director contacted us to say they had made contact with relatives who had previously made complaints to discuss these further.

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

- People and their relatives were not always able to have full choice and control over their care. Although there was person centred information in people's care plans, it was not clear if or how this had been used to design people's care.
- Two relatives told us they had repeatedly requested sight of their relations care plan but not been given access to this. This meant they did not feel they were partners in their relations care.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow, and they make sure there are audio books available." 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.

● People's communication needs were assessed but were not always met. For example, signage around the home, such as menus and activity plans were in typed format that people with sensory loss would not easily be able to understand. This was identified at the last inspection and the provider had failed to make changes to improve this.

● Staff knew how to effectively communicate verbally with people. Relatives told us they felt their relations communication needs were met. One relative said, "[Staff] make sure there are audio books available."

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 the

● People were not always supported to take part in activities to keep them active and stimulated.

● People who preferred to spend time in their bedrooms did not always have access to meaningful activities.

● We reviewed one person's care records that showed they had not been offered any form of activity for nine weeks.

● One relative said, "There are activities but my relation stays in bed so there is nothing for them." A different relative said, "My relation doesn't do activities, [Staff] say they will start this now they have more staff."

● People and relatives told us they enjoyed the activities provided in communal areas. One relation said, "The activities are quite good, [Name] likes the carpet bowls."

● People were supported to maintain relationships that were important to them. Relatives told us they were welcomed to visit and spend quality time together.

End of life care and support

● People's wishes for how they would prefer to be supported if they were to approach the end of their lives were not always explored.

● Records were not clear about whether one person had a valid Do Not Resuscitate Order (DNACPR) or not. Their care plan stated they did not, but the staff handover records stated they did. This meant there was a risk that staff would not know what to do in the event of a person becoming suddenly unwell.

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 inadequate. At this inspection the rating has remained the same. 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.

At our last inspection 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 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to ensure they operated effective systems to assess and improve the care provided. They had failed to ensure there was effective scrutiny at senior management level. This meant people continued to be exposed to unsafe care and treatment.
- Since the last inspection the provider was required to submit a monthly report to CQC detailing the improvements in governance they had made. At this inspection we found the improvements they had assured us were in place were not. People remained at risk of harm.
- The provider's governance system had failed to identify the serious risk of harm we found during this inspection. The same risks were also identified at the last inspection and the provider had failed to implement improvements.
- There was no effective oversight of people's daily care records including unexplained injuries, food and drink, behaviours that challenge, weights, accidents and incidents, pressure relieving equipment, risk assessments, environment or medicines. Therefore, there was no system by which people's needs and care were reviewed, and people remained at risk of avoidable harm.
- Immediately after the inspection we asked the provider to implement improvements to ensure people were protected from the risk of harm. They responded with information about managing some risks but failed to immediately offer assurances of how they would protect people from the risk of unexplained injury.

The provider had failed to ensure they had effective oversight of the service and failed to implement improvements which left people at risk of harm. This is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 they always met the duty of candour. During this inspection we alerted the manager to multiple cases of unexplained injuries and people at risk of harm. They had not identified this before. After the inspection the manager completed incident forms for these. However, they noted on the incident forms that people, their relatives and external professionals would not be informed because they classed the incidents as historic.

● Some relatives told us they had identified unexplained injuries on their relation and had not received any response when they asked about this. One relative said, "[Name] had a cut, I asked how it happened but was never told." A different relative said, "I noticed a cut and a bruise, no-one has contacted me about it."

The provider had failed to ensure they were always open and honest when something had gone wrong. 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us the service was not well-led. Three relatives told us they had repeatedly raised concerns and did not always receive a reply, they told us they were looking for a new home for their relation.

● One relative said, "The manager doesn't listen and doesn't do the things they say they will do; I'm always having to chase for things." A different relative said, "The manager doesn't answer my queries."

● Other relatives felt the home was well-led. One relative said, "Everything is fine from what I see." A different relative said, "Everything has been great, the manager has been lovely with us."

Working in partnership with others

● The provider had failed to work in partnership with external professionals. There were multiple times when healthcare professional guidance was not followed. Referrals to safeguarding professionals were not always made. Support from commissioners had not been sought since the last inspection.

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

● The manager had sent out surveys to people and relatives to gain their views. However, they told us the results had not yet been analysed so had not been used to recognise where improvements may have been required.

● Staff told us the support they received had improved since the last inspection.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure they took proportionate action in response to failures identified by complaints.

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 did not always follow safe recruitment practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to ensure they were always open and honest when something had gone wrong.

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 people received safe care and treatment.

The enforcement action we took:

Urgent NOD imposing conditions. NOP to cancel location

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 people were always protected from the risk of harm.

The enforcement action we took:

Urgent NOD imposing conditions. NOP to cancel location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure people's nutrition and hydration needs were met.

The enforcement action we took:

Urgent NOD imposing conditions and NOP to cancel location

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 maintain effective oversight of the service. The provider had failed to implement improvements since the last inspection. The provider had failed to ensure there were effective systems in place to assess, monitor and improve the service. People remained at risk of harm.

The enforcement action we took:

Urgent NOD to impose conditions. NOP to cancel location.

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 they supported staff to undergo training to know how to support people effectively.

The enforcement action we took:

Urgent NOD imposing conditions and NOP to cancel location