Precious Care Homes Ltd

Precious Nursing & Residential Home

Inspection report

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12 January 2023

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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
Precious Nursing & Residential Home is a residential care home providing personal and nursing care to up to 38 people. The service provides support to people living with dementia, mental health support needs, physical disabilities and sensory impairments. At the time of our inspection there were 25 people using the service.

People's experience of using this service and what we found
The provider had not always made the safeguarding adults team and CQC aware of safeguarding concerns. People did not always have support to keep their belongings secure. Environmental risks were not always managed. People did not always receive their medicines safely and guidance was not always available to staff about when people needed 'as required' medicines. People were not always repositioned when they needed to be to promote their skin health. However, the service promoted clean hygiene practices and staff were recruited safely.

Staff had not always completed training they needed to meet people's needs effectively. People's health and mobility related needs were not always monitored consistently. Health professionals told us of concerns relating to their advice not being implemented. We received and observed mixed findings about people's mealtime experiences. People's bedrooms were not personalised unless they had support from relatives or external professionals. However, people had their needs assessed prior to them using the service.

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; despite the provider's policies in the service supporting this practice.

People could not always access their care plans to enable their involvement and empower them to ensure their needs and preferences could be understood and met. People did not always have enough clothes to wear due to poor laundry processes . However, a relative felt positive about the care a person received and we observed staff respecting people's privacy.

End of life plans were not always in place for people. Complaints and concerns had not been recorded or acted upon. People's care plans were not always fully personalised. Improvements were needed so people could engage in activities meaningful to them. Accessible information was needed to enable people to seek support outside of the service. However, care plans did contain information about people's communication needs.

There was not always effective management oversight of the service. Audits had not always been carried out or used to identify shortfalls in quality and improvements needed. Accurate and complete records were not always kept. The provider had not met all of their regulatory requirements. People were not always spoken

about in a positive way. However, staff felt comfortable with approaching the registered manager with concerns.

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

Rating at last inspection
This service was registered with us on 11 January 2022 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service. 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.

Enforcement
We have identified breaches in relation to safeguarding, people's safety, the safety of the premises, staffing, dignity and respect, consent and governance.

Please see the action we have told the provider to take at the end of this report. 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 is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

Precious Nursing & Residential 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 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. The Expert by Experience spoke with people and their relatives to obtain their opinion of the service.

Service and service type
Precious Nursing & Residential 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. Precious Nursing & Residential 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.

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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We contacted Healthwatch for information they held about the service on their records. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 3 relatives about their experience of the care provided. We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service.

We spoke with 10 staff including domestic staff, the maintenance person, kitchen staff, care staff, senior care staff, nurses, the deputy manager, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed 6 people's care records. We looked at 4 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, quality assurance reports and accidents and incidents.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from the risk of abuse. Not all staff had completed safeguarding training. The provider had not worked well with other agencies to share safeguarding concerns.
- Accidents and incident reports documented allegations of abuse which had not been referred to the local authority safeguarding adults team. Concerns ranged from allegations of physical abuse to neglect. Furthermore, people showed us concerns on their phones of alleged poor staff conduct towards them, and records showed the provider was aware of these. This meant safeguarding concerns were not always independently reviewed to ensure people were protected from abuse and to decide how they should be investigated.
- There was not always evidence safeguarding concerns had been reviewed by the registered manager or the provider. This meant the provider's systems to monitor safeguarding concerns were not effective in ensuring they had oversight and concerns were investigated appropriately.
- The registered manager was able to give us examples of safeguarding concerns they should report and understood their responsibilities. This meant the registered manager had failed to act on safeguarding concerns despite having the knowledge to do so.

The provider had failed to ensure that systems and processes were operated effectively to safeguard people from the risk of abuse. This was a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People did not always receive support to keep their belongings secure. One person needed to have their stock of cigarettes monitored to prevent theft. Records indicated cigarettes were missing and not accounted for. Another person had gone to the hospital the previous weekend, their room had been left unlocked and contained items of value. One person told us, "Stuff is being nicked from my room." Another person said, "I get well looked after, but nobody seems to be interested in my money going missing." This meant people were at increased risk of financial and material abuse.

Assessing risk, safety monitoring and management

- Window restrictors were not fitted to all windows. We found 8 bedrooms above the ground floor did not have window restrictors fitted. This increased the risk to people who could fall out of windows. The provider arranged for window restrictors to be fitted during our inspection.
- Wardrobes were not always secured to walls. Some people were at greater risk of falls and may attempt to grab or use furniture to stop themselves falling or to pull themselves back up, which increased risks to them. There was no evidence this risk had been assessed or mitigated.
- People had access to areas where they could be harmed or injured. During the inspection, we found

several rooms and storage areas were left unlocked, containing items that could be a danger to people. For example, in one of the bedrooms, we found tools such as hammers and wallpaper scrapers. Furthermore, we found people could have accessed scissors as the hairdressing salon had been left unlocked when it was not in use. This meant environmental risks were not always managed to ensure people could not access areas that were unsafe. The provider responded to our concerns and arranged for these areas to be secured during our inspection.

The provider failed to ensure the premises was secure with sufficient regard to people's personal safety and the security of their possessions. This is a breach of Regulation 15(1)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had access to substances which could be hazardous to their health. We found cleaning items were stored in an unlocked cupboard in the first-floor kitchen. This increased safety risks to people who could come into contact with or ingest these items.
● Fire-related risks were not always well managed. We found a fire door did not close properly into the frame, exposed wiring to a door closer, and a fire door on the first-floor kitchen being held open by a chair. Weekly checks on fire equipment, such as alarms and extinguishers, were not current. This meant there were increased fire-related risks to people.
● People were not always repositioned when they needed to be. People are repositioned to help prevent skin tissue breakdown when they cannot do this for themselves. Records showed people had not always been repositioned by staff in line with their care plans to manage these risks. This increased health-related risks to people.
● Safety monitoring equipment was not always used effectively. We found a person had a movement sensor in their bedroom, but it had been positioned in an area of their room where it was not effective. This meant this person was at increased risk of injury.
● There was evidence a person had been hoisted in a damaged sling. The nominated individual told us the person had refused to use a new hoist sling which had been purchased for them. However, the provider and registered manager were responsible for the care being delivered. This meant the person and staff were put at foreseeable risk of injury through the continued use of damaged equipment. Alternative options had not been considered by the provider, such as raising safeguarding concerns.

Learning lessons when things go wrong
● Accident and incident forms did not always evidence they had been reviewed by a manager. There was no evidence untoward events such as falls had been analysed to identify themes and trends. This meant lessons could not always be learnt, and risks were not always reviewed and managed.
● Staff did not always record who had been affected by incidents and accidents. Records showed people had been assaulted, but it was not always documented who these people were. This meant there was not always evidence of the support victims received or actions taken to manage risks to them.

Using medicines safely
● Protocols for medicines taken by people on an as-required basis (PRN) were not always in place. PRN protocols give guidance to staff about when a medicine can be given, the reason it is prescribed and safety information. This meant staff might not know why and when people needed to have these medicines to support their health.
● Records were not signed to evidence people had received their topical medicines. Topical administration records did not always detail where topical medicines, such as prescribed creams, should be applied. In addition, one person told us they had been without 1 of their topical creams for the past week. This meant there was an increased risk of people not receiving their prescribed topical medicines.

● People with flammable emollient creams who smoked had no risk assessments in place for staff to follow to support people if an emergency should occur. This increased safety-related risks to people.
● Opening dates were not always recorded on people's medicines. We found a person had a topical cream in their bedroom, which had not been labelled at the time it was opened. This increased the risk of people receiving medicines that were no longer safe for use.

Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate health and environmental risks to people. The provider failed to ensure people received their medicines safely. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 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.

Visiting in care homes
● Relatives told us they were able to visit without restriction. We observed visits taking place throughout the inspection.

Staffing and recruitment
● We found staff had been safely recruited with appropriate references and Disclosure and Barring Service (DBS) checks in place prior to their appointment. DBS checks provide information, including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Not all staff had completed the training the provider deemed was required. Records showed 21 staff had not completed moving and handling training. 17 Staff had not completed safeguarding training. 21 staff had not completed health and safety training. We could not find evidence of any staff who had completed all training. This increased the risk of staff not having the skills to meet people's needs effectively.
- There was no evidence staff had completed diabetes, tissue viability and epilepsy training, despite supporting people living with these or associated conditions. There was no evidence of learning disabilities or autism training, a legal requirement of the Health and Care Act 2022. This increased the risk of staff not having the skills to meet people's individual needs effectively.
- A new member of staff told us they had not yet completed any training, but had been allocated to support a person who needed 1 to 1 support to promote their safety. The member of staff did not yet speak English fluently, and the person they were supporting had complex mental health support needs. The communication barrier and lack of training increased safety risks to the member of staff and the person they were supporting.

The provider did not ensure all staff were sufficiently trained. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's weights were not always recorded or monitored consistently. One person's care plan stated they needed to be weighed monthly, but records showed they were last weighed in August 2022. A community nurse told us one person needed to be weighed weekly due to health concerns, but this had not been done. Furthermore, we found a person's electronic air mattress settings were not correct for their weight to effectively manage risks to their skin. This meant there were increased health-related risks to people due to inconsistent weight monitoring.
- People's needs were not always documented on their care plans. For example, one person was not able to mobilise without staff support, but their mobility care plan had not been completed. This meant there was an increased risk of staff not having the guidance they needed to support this person to mobilise safely.

Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate health risks to people. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was evidence the provider carried out assessments of people's needs prior to moving into the

service. The deputy manager told us they carried out the assessments by meeting the person and speaking to people who were involved in their previous care arrangements. We reviewed documented evidence of this and found people had been appropriately assessed.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We found no documented evidence of decision-specific mental capacity assessments. This meant staff had made decisions on behalf of people, such as using movement monitoring equipment and bedrails without confirming people's understanding of these decisions and attempting to confirm their consent. This meant there was an increased risk of people's rights not being upheld.
● The provider had not used available skills and knowledge to ensure people's consent was considered for their care and treatment. This was despite the nominated individual telling us they were a DoLS assessor and a psychiatrist. A DoLS assessor is a person who has received specific MCA training to assess if depriving someone of their liberty is in their best interests. Usually, DoLS assessors are professionals with medical backgrounds, which also help confirm if people cannot make particular decisions due to the conditions they are living with. This meant procedures were not implemented to obtain people's consent despite the provider understanding their responsibility to do so.
● Although training was available, records showed 18 staff had not completed MCA training. This meant the provider had not always ensured staff had received training to ensure they were familiar with the principles and codes of conduct associated with the MCA to support people in line with guidance and the law.

The provider failed to ensure they acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, there was evidence the provider had submitted applications where needed for authorisation to deprive people of their liberty.

Supporting people to eat and drink enough to maintain a balanced diet
● We had received concerns from relatives and people prior to the inspection about the quality and quantity of food within the service. One person told us they had lost weight, and although they felt this was beneficial, they felt it was "forced" on them. On both days of our inspection, the food provided was described by one person as, "More than usual" and another person as, "Nicer, because you are inspecting."

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

● A visiting community nurse told us they had concerns about the provider implementing their professional guidance, such as weighing a person weekly and checking their blood pressure monthly. This meant there was an increased risk of people not receiving appropriate care to have their needs met.

The provider did not ensure people received person-centred care which met their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed people receiving appropriate support from staff with their meals when this was required.

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

● We observed that most people's bedrooms were bare and without personalisation. However, we saw a few people and their relatives had chosen how their bedrooms were personalised. A visiting health professional told us their team had been involved in the decoration of a person's bedroom. This indicated people were only able to personalise their bedrooms when they had relatives or external professionals to support them in doing so.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● People and their relatives were not always involved in planning their care. One person told us they had been denied access to view their care plans when they had requested this. This meant people were not always involved in the development of their care plans.

The provider did not ensure they always worked collaboratively with people on their care plans. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity
● People and their relatives shared their concerns with the inspection team about a lack of available clothing. We observed people's bedrooms did not always contain sufficient amounts of clothing. For example, on both days, we found 2 people did not have enough clothes in their bedroom to complete a full change if needed. Another person told us they were disappointed because their laundry basket was full of soiled clothing. The provider told us this was because clothes had become mixed up in the laundry, and this would be improved as they would put labels on people's clothes.

The provider had failed to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

● A relative we spoke with provided positive feedback regarding the support staff offered to their family member. One relative said, "My [family member] is just settling in here. They [staff] have been brilliant with them. They have given my family member their dignity back and are catering for their individual needs at this time."
● Staff were aware of people's right to privacy. For example, we observed staff knocking on bedroom doors prior to entering and addressing people by their preferred names.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

End of life care and support

● People's end of life care plans were not always completed. One person who did not have an end of life care plan was deemed to be at the end stage of their life. This meant care plans did not always contain information on if decisions had been made about people receiving life-sustaining treatment and to guide staff on respecting people's wishes for the end of their life.

The provider had failed to ensure people were treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

Improving care quality in response to complaints or concerns

● Complaints and concerns had not been recorded. Before the inspection, we were aware of complaints made to the provider. During the inspection, people told us they had raised concerns and complaints with the provider, but we found the complaints folder to be empty. Complaints and concerns ranged from concerns about staff conduct to quality of food and medicines. This meant there was no evidence of complaints being investigated and actions being taken to address people's concerns.

The provider did not effectively operate systems to receive and respond to complaints. This increased the risk of care not improving following complaints. This was a breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's care plans did not always include their personal history, individual preferences and interests. There was not always information about who people were other than their assessed care-related needs. Furthermore, during the inspection, we observed staff had put on afro beats music in the upstairs lounge. None of the people appeared interested or showed they enjoyed this. During this time, staff positioned themselves standing between people, watching them rather than engaging with them. This meant there was an increased risk of people not having support to access things they enjoyed, activities they preferred and interests they might want to pursue.

The provider did not ensure people's care plans reflected their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, relatives and staff told us there were not enough activities offered for people to engage in. We

found the activity timetable was not up to date. However, the service employed an activities coordinator who supported people to take part in activities. We observed this staff member working with small groups of people in the downstairs lounge.

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

● We did not observe the service providing information in accessible formats to people. Improvements are needed to display signage and ensure people have access to information on areas such as advocacy or raising concerns.
● People's care plans included information on their communication needs. For example, one person's care plan guided staff to use shorter sentences to aid understanding.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- There was not always effective management oversight from the registered manager and the provider. The registered manager and nominated individual told us a previous manager had been responsible for implementing auditing systems and reviewing incidents and accidents. They told us, "This had left a gap in the role." This meant the provider had not promptly reviewed arrangements to ensure the quality of the service and drive the improvements we found were needed.
- Systems to assess staff learning needs were not established. As cited in the 'Effective' part of the report, the provider had failed to ensure staff received training where people had specific health-related needs. This increased the risk of staff not having the skills and knowledge they needed to meet people's needs.
- Call bell response times were not monitored. The registered manager was unable to tell us if there was a set time for staff to respond to people. During the inspection, a person told us they had been ignored when they pressed their call bell and wanted support to get out of bed. This meant call bell response times were not monitored to help inform staffing and proactively manage people's needs when they were most likely to need support. We raised this with the provider, who told us they would introduce a system to analyse call bell responses.

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

- Medicines audits had not been carried out. There were no systems being operated to identify the concerns we found in relation to medicines at this inspection. This meant there was an increased risk of unsafe medicines administration practices not being addressed.
- Accurate and complete records were not always maintained. We found documentation was not always completed in areas such as weight monitoring, mobility and end of life care planning. This increased the risk of people's health, safety and preferences not being met.
- The provider had failed to implement and follow their safeguarding policy. The registered manager had not followed the provider's policy to report safeguarding concerns to the local authority safeguarding adults team. This exposed people to the increased risk of abuse.
- The provider's electronic recording systems had not been reviewed to identify people who had not been repositioned or weighed in line with their assessed needs. This meant the provider had not independently identified and addressed these concerns prior to our inspection, increasing health-related risks to people.
- Oversight of environmental risks where not effective. The provider had not independently identified risks related to fire, window restrictors and areas where people could get harmed or injured to mitigate risks to people.

The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to submit all statutory notifications to CQC. We found the provider had not made us aware of all allegations of abuse. This is a requirement of them being a registered provider. Information we get from statutory notifications tells us how the provider has responded to concerns and can help inform us of when we next inspect a service. This meant the provider did not always meet their regulatory responsibility. We will continue to monitor this.

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
● The nominated individual told us in relation to 2 people who had made us aware of their concerns, "We are doing them a favour by taking them both in at the service." Later the nominated individual told us in relation to safeguarding concerns raised by a person, which had not been referred to the safeguarding adults team, "[person] has a history of making complaints at previous locations, we are doing ICB (integrated care board) a favour having [person] here." This meant there was an increased risk of people not being empowered to have their concerns heard.

The provider did not ensure people were always treated with dignity and respect in relation to their protected characteristics. This was a breach of regulation 10(2)(c), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two people told us the registered manager did not make themselves available to speak with them. For example, 1 person told us they did not find the registered manager to be unpleasant, "but they're always busy or in the office." They went on to tell us they had limited opportunities to speak to the registered manager about their concerns. This meant people did not always feel confident in raising their concerns to the registered manager.
● We saw no records of regular staff meetings and supervisions. This meant there were limited opportunities to involve staff in improving the service and get their feedback. However, the majority of staff told us they felt able to raise concerns with the registered manager.

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 understood their responsibilities to act on the duty of candour and had policies to promote them meeting their legal responsibilities.

Working in partnership with others
● The registered manager had not always made referrals for people to the safeguarding adults team or ensured guidance from professionals had been robustly implemented to achieve the best outcomes for people. The provider had not submitted all required notifications to CQC. This meant external professionals could not support risks to people's health, safety and well-being being managed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had failed to ensure people received care that was appropriate, met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had failed to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had failed to ensure care and treatment was provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems were not effectively established to assess monitor and manage risk to people. The provider did not ensure medicines were administered safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Safeguarding service users from abuse and improper treatment The provider had failed to ensure that systems and processes were operated effectively to safeguard people from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises was secure with sufficient regard to people's personal safety and the security of their possessions.

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 act and investigate complaints.

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 Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service.

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 people received safe care by deploying sufficient trained staff to meet their needs.