Rosa Mistica Ltd

Rosedale Residential Home

Inspection report

68 Rockingham Road
Kettering
Northamptonshire
NN16 8JU

Tel: 01536512506

Date of inspection visit:
02 October 2017

Date of publication:
14 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Rosedale Residential Home provides accommodation and personal care for up to 19 older people, some of whom are living with dementia. On the day of inspection there were seven people living at the home.

We carried out a full comprehensive inspection because we had received information of concern from people's families, staff and the local authority.

There was no registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider did not have sufficient oversight of the management of the home to identify that people were receiving unsafe care.

There had been multiple concerns raised by people's families and staff to CQC. These included people not receiving their medicines, people not having enough to drink, people being moved in an unsafe way and people not receiving their personal care. These had been raised as safeguarding alerts which had been investigated and substantiated. This meant that all of the concerns had been proven to be true.

CQC worked closely with the safeguarding team and the local authority that commissioned care from the home to keep people safe. Referrals were made to other agencies to provide training, guidance and support in areas such as fire safety, food hygiene, medicines management and moving and handling. These agencies continued to provide input into the home as there was insufficient management to implement the safe systems and embed them into practice.

The local authority placed a suspension on the home, preventing any new people from being admitted whilst the care was unsafe.

The provider considered the response from the agencies involved in people's care and decided to close the home.

CQC worked with the safeguarding team and local authority to activate the home closure procedure recommended by the department of health.

At the time of inspection the local authority were carrying out daily visits to monitor the management of people's care including the monitoring of staffing levels, medicines management, moving and handling, food hygiene and people's health and well-being.

People were anxious about moving to a new home. The local authority had appointed care managers to

support people to find a suitable new home. People's risk assessments and care plans did not reflect all of peoples current care needs and this meant that people's commissioners struggled to ascertain people's specific care needs.

Staff did not have adequate supervision and people were not always receiving their planned care. People were not always receiving enough to drink to maintain their health and well-being. Food was not always stored in a safe way. This was being closely monitored by the local authority on a daily basis.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

There were nine breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have taken can be seen at the end of the full report.

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.

The provider did not have suitable systems in place to safeguard people from unsafe care or treatment.

The provider had not managed people's medicines safely.

Staffing levels had not been adequate to meet people's needs.

Risk assessments were in place however these did not always reflect people's current needs.

The provider had not ensured that people were kept safe in the event of a fire.

The provider had not ensured that people were protected from the risks of unsafe food handling and kitchen cleanliness.

People were not always protected from the risk of unsuitable staff as the provider did not always follow their safe recruitment procedures.

Is the service effective?

Inadequate

The service was not effective.

People were cared for by staff that had not got the skills, knowledge or competencies to provide safe care.

Staff did not receive the supervision or support they required to carry out their roles.

People did not receive a well-balanced diet or food that helped them to maintain their health and well-being.

People did not always receive enough to drink to help maintain their health and well-being.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and people's consent was recorded.

People's health needs were monitored and responded to appropriately.

Is the service caring?

Inadequate

The service was not always caring.

People's dignity was not always maintained and people were not always treated with respect.

People were not always listened to.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's needs were not always met in line with their individual care plans and assessed needs.

People's complaints had not always been addressed appropriately; the provider did not always follow the complaints procedure.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager.

There was a lack of provider oversight of the management of the home. This had led to unsafe care.

The provider did not have suitable systems in place to identify and monitor the quality and effectiveness of the care that people received.

The provider did not listen to people who used the service, relatives or staff about the poor management of the home.

Rosedale Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on 2 October 2017 by one inspector.

We carried out this inspection following information of concern from members of staff and the public. This led to a safeguarding investigation which was undertaken by the Local Authority and found all of the concerns to be substantiated.

Before the inspection we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted and met the health and social care commissioners who monitor the care and support of people living at Rosedale Residential Home.

During this inspection we spoke with three people using the service. We spent time in the communal areas and observed the interactions between staff and people using the service. We also spoke with four members of staff including the provider, the deputy manager, a care worker and the cook. We reviewed the care records of people that used the service including medicines records, daily records, charts and one care plan.

Inadequate

Is the service safe?

Our findings

People were not protected from unsafe care or treatment. Although there were policies and procedures in place to safeguard people from harm, the provider did not have a system to monitor whether the manager and staff had followed them or protected people from the risk of harm. In July and August 2017 families and staff had contacted CQC to raise their concerns about the lack of management in the home, low staffing levels, missed medicines, and unsafe moving and handling procedures. CQC raised safeguarding alerts with the local safeguarding authority that carried out an investigation. The safeguarding investigation found all the alerts to be substantiated. This means that the safeguarding authority found that all of the concerns were proven to be true. The safeguarding team created a protection plan to impose safe working practices in the home to protect people. However, the manager did not have the skills or managerial experience to implement the protection plan; the local authority quality monitoring team found they needed to visit the home every day to provide guidance and support to the provider and staff to ensure people received their medicines and enough food and drink to maintain their health and well-being. The provider required constant monitoring and guidance on how to meet the protection plan.

The provider had not recognised their procedures did not protect people. Not all staff had received adequate training in safeguarding of vulnerable adults. Staff had reported their concerns to the manager and deputy manager who did not know how to report a safeguarding concern.

The provider told us and the local authority they had concerning information about an ex-employee who is now providing care within another organisation. The provider would not provide this information to the safeguarding authority as they 'did not want to get the ex-member of staff into trouble'. There was a risk that the ex-member of staff was not providing safe care, yet the provider would not protect these people by carrying out their duty to raise a safeguarding alert. The provider has not followed their own procedures or carried out their duty of care to protect vulnerable people who use services.

The provider did not protect people from the risks of harm. This is a breach of Regulation 13 (2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

People did not always receive their medicines as prescribed. We had received information from staff and families about people not getting their medicines. We reported these incidents as a safeguarding alert; this was investigated and found to be substantiated. The care home pharmacy team was appointed to carry out a medicines audit. They found that people were not receiving all of their medicines; staff had signed to say the medicines had been administered but the medicines were still present in the packets. People were at risk of deteriorating health due to the missed medicines. One person was admitted to hospital for treatment as a result of not receiving their medicine for epilepsy. Another person was at risk of conditions relating to blood clots, such as a stroke or heart attack as they had not been receiving their blood thinning medicine as prescribed.

There was no adequate systems in place to ensure that people's prescriptions matched their Medicines

Administration Records (MAR) charts. The pharmacy team contacted people's GPs to gain an up to date prescription to compare with people's MAR charts. They found that staff had stopped giving some medicines when there had been no indication to do so; one of these medicines was an antidepressant which the guidelines state should not be stopped abruptly as this can cause intolerable symptoms. Some medicines had continued to be given, such as antibiotics when they should have been stopped.

The pharmacy team implemented a system for staff to check the medicines stock levels. The provider and staff struggled to understand what was required of them at first, however, after five days we saw that staff now understood how to record the stock of medicines. The pharmacy team continued to visit the home to monitor the management of medicines and continued to provide guidance.

The provider had not ensured that staff were competent to administer people's medicines. They had been prompted by the pharmacy team to assess staff competencies; however, not all staff had been tested at the time of inspection.

Although a system had been imposed by the pharmacy team to manage the medicines safely, staff required the support and scrutiny of the pharmacy team to maintain the system as it had not been embedded into practice. There was a continued risk that people were not receiving their prescribed medicines. This constitutes a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

There had been no suitable system in place to carry out an assessment of the safety of the premises including fire safety checks. In September 2017 the local authority quality monitoring team identified concerns with the lack of fire safety systems in place. There had been no safety checks carried out since the registered manager left in July 2017. The local authority referred the home to Northampton Fire and Rescue Service. Their fire protection officer visited the home and placed a fire safety order on the home. This was a set of instructions to implement safe systems in the home. The fire alarm system was in good working order. They then visited seven days later and ensured that the provider understood where all the manual call points for the fire alarm were and confirmed that the open communal doors automatically closed on activation of the alarm. Although the provider had implemented systems to check the premises for fire safety and evacuation, it had taken the input of the local fire protection officer to implement this system. The system of carrying out weekly fire checks and practicing for an emergency had only been recently re-introduced and had not been embedded into practice.

People could not be assured that their food had been stored and prepared in a safe way. The environmental health officer had visited the home following concerns raised by the local authority. They had found that the kitchen was dirty and food had not been stored safely. A follow up visit found that although the kitchen had been cleaned staff were not always ensuring that food was covered or stored safely. During our inspection we found that food was not always safely stored. For example there was a frozen chicken defrosting in the fridge on the shelf above the salad. There was a risk of contamination from the defrosting meat onto the salad. We brought this to the attention of the cook, who stated they would place the chicken onto a tray to protect the salad. We referred the home back to the environmental health officer.

Staff did not have the skills and competency to provide people with safe care. The local authority witnessed staff using a drag lift to move somebody; this involved staff placing their arms under people's armpits and dragging them. This lift has been proven to be dangerous as it can cause injury to people's arms and their skin through the dragging motion. The local authority arranged for their moving and handling assessment team to assess all the staff for their skills and competency in safe moving and handling. During their assessment they also witnessed staff using the drag lift. All staff received training and assessment in safe

moving and handling. At the time of inspection all staff had received the training and we observed staff moving people in a safe way. However, the provider had known that staff were using the drag lift, they did not recognise it was unsafe practice and posed a risk to people. The provider was not aware of best practice or understood what safe moving and handling looked like and relied upon the local authority to update staff and provide training.

There was a continued risk that people's food may not be stored correctly, that safety procedures in the event of a fire and safe moving and handling were not embedded into practice. This constitutes a breach of Regulation 12(1) (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People's risks assessments had been reviewed by the manager in August 2017. The care plans provided instructions for staff to reduce the risks that had been identified. However, people did not receive all of the care they required to mitigate the risks. For example one person required their feet to be placed onto foot plates when using their wheelchair to prevent them from falling out of the wheelchair. We observed this person in their wheelchair for at least an hour; their feet were on the floor and the foot plates were not in place. They also required a pressure relieving cushion to prevent the risk of pressure ulcers; we saw that there was no cushion on their wheelchair. This meant that staff did not follow people's plans to reduce the assessed risks.

The local authority was arranging to move everyone to a new home; they had assessed everyone for their dependency. This was required as they needed to be sure that their new home could meet their needs. They told us that the individual risk assessments for people had not provided the information they required to effectively assess people's current needs and had to carry out full assessments without up to date relevant information.

The provider did not do all that was reasonable to mitigate known risks to maintain people's health and safety. This constitutes a breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The provider had not recruited any staff since our last inspection. However, the provider had appointed a manager through the recommendation of friends at church. The recruitment procedures operated by the provider failed to consider whether people had the competence, skills and experience that they required to work safely and effectively in their role. The manager did not have the skills and experience to manage a residential home. The provider had not gained references from the manager's previous employers, instead they had accepted pre-written references supplied by the manager themselves. The provider did not verify these references with the manager's previous place of work.

The manager did not know how to manage people's needs and was not aware of who was employed by the service or their skills and competencies. The manager did not have any knowledge of the systems and process to employ staff safely. They were unaware of the need for interview or to carry out criminal checks and references. This was raised as a safeguarding alert following concerns raised to CQC and was substantiated by the safeguarding investigation. A protection plan was put in place by the safeguarding team, which resulted in the provider not employing the manager anymore. The home is currently being managed by the provider.

The provider did not ensure that the manager had the qualifications, competence, skills or experience to manage the home. The provider failed to take suitable steps to ensure the manager was of good character. This constitutes a breach of Regulation 19 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014Fit and proper persons employed.

People did not always receive care that met their needs. There had been safeguarding alerts which highlighted that people were not receiving their care due the lack of staff. In September there was one day where there was only one member of staff on duty to provide care for 10 people, eight of these required two care staff for their personal care. People had to stay in bed until more staff arrived. Care staff were also allocated to kitchen or domestic duties which meant that staff were not available to provide people's care.

The lack of staff meant that people who were at risk of pressure ulcers were not helped to move to relieve their pressure areas regularly. People's skin was at risk of breaking down due to the lack of staff to carry out personal care and continence care. A safeguarding alert was raised by CQC, the safeguarding investigation was substantiated and there was a protection plan put into place. The protection plan gave clear instructions to the provider of the steps they had to take to ensure that people's dependency was calculated and staff were allocated accordingly. This protection plan was being monitored on a daily basis by the local authority to ensure that people received their care; they told us that the provider required daily guidance to carry out the protection plan as they did not know the needs of people very well.

There were enough staff to provide for people's care needs at the time of inspection, although this was kept under close scrutiny by all agencies. The provider had taken action to retain staff whilst the home was closing. The provider was present at all times as they had moved into the home to provide managerial guidance.

The provider had failed to ensure that there were enough suitably qualified, skilled and experienced staff deployed to meet people's needs and was prompted to do so following a safeguarding investigation. This constitutes a breach of Regulation 18 (1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Inadequate

Is the service effective?

Our findings

People could not be assured that staff had received all the training they required to provide care to meet people's needs. The safeguarding investigation and outside agencies had identified that staff did not have the competencies to manage people's medicines, safely move people or understand what to do in the event of a fire. The local authority arranged for outside agencies to provide emergency training to staff to ensure that people were safe during the time that the home was closing.

Staff had not received the support and supervision they required to carry out their roles. Staff did not have suitable supervision to identify that they did not have the competencies to carry out their roles.

The staff in charge of the kitchen and food safety did not have the competencies to understand when they were storing food unsafely or that there was a risk to people's health because of a dirty kitchen. The kitchen staff did not have the skills or knowledge to create a nutritionally balanced menu.

The provider had not ensured that staff had received the support and training they required to carry out their roles. This constitutes a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

People did not have access to a healthy and varied diet, which would help to maintain their health and well-being. Most meals served did not include vegetables. The food that was served did not look appetising or appear to be hot. For example one person had asked for jacket potatoes and butter. This had been served in the dining room, and was there for at least five minutes before the person sat down to eat their meal. We observed that the butter in the jacket potato remained solid, the butter did not melt, indicating that the potato was not warm enough to melt the butter. We asked the person about their meal, they told us "The food could be better; I don't seem to have an appetite anymore."

The evening meal was pre-prepared. The cook showed us they had cooked tuna pasta for people's evening meal. However, they said that not many people would eat the pasta, so there were jam sandwiches in the fridge if people wanted them. We saw there was a large tray of jam sandwiches prepared ready in the fridge. People were at risk of deteriorating health as they did not have a healthy or varied diet.

People did not always get enough to drink to maintain their health and well-being. Safeguarding alerts had been raised in August where three people had been admitted to hospital with symptoms of dehydration and urine problems related to dehydration. A safeguarding investigation found this to be substantiated.

Although people had drinks readily available to them in the day time, some people required prompting to drink and there was no record of what people drank after 8pm. People did not always have enough to drink to maintain their health. For example, one person had been assessed as at risk of dehydration. This person had been seen by their GP on 25th September as they appeared more sleepy than usual, the GP advised staff to ensure they had plenty of drinks. Their care plan stated that they required between1500mls and 2000mls of fluid a day. We looked at the fluid charts for the days following the GP visit (26 to 28 September)

and saw that they had not had the recommended amount to drink. Staff had recorded they had between 950mls and 1330mls a day. This person remained at risk of dehydration as staff had not provided the fluids they required to remain healthy. We notified the local authority team who visited the home every day to continue to monitor this person closely.

The provider did not ensure that people's nutritional and hydration needs had been met. This constitutes a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

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 Act 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There was one person in the home who were subject to a DoLS.

Staff understood their roles in ensuring people's capacity to make decisions. They ensured they attained people's consent before providing their care.

Staff maintained records of when healthcare appointments were due and carried out, such as hospital appointments. Staff supported people during GP or district nurse visits.

Inadequate

Is the service caring?

Our findings

Staff knew people very well and understood how to communicate with them. People had developed positive relationships with some of the staff over many years. One member of staff described how they took one person, who had no family, out to places and involved them in their family life. They told us they were going to miss them when the home closed.

People were not communicated with in an open and honest manner. The provider held a residents and relatives meeting to announce they were closing the home, but they failed to explain the reasons for the closure. Staff from the local authority who attended the meeting were left to explain to people and their relatives that the home was closing. One person said "I can't remember why they are closing, money I expect. I know it's their choice." The provider had not considered people's emotional well-being and the way in which information was shared about the home closure made them feel anxious. One person told us "I am not happy, I don't feel very good, and I feel sick." They told us they were worried about moving home. Staff told us that people were anxious; one said [Name] feels ill, they are disorientated and feel sick with worry. Some people are not eating; all we can do is keep people safe."

People were not always treated with respect. The provider was responsible for the costs of moving people to their new homes. One person was due to move to another home on the day of our inspection. At midday, their belongings had not been packed, staff told us that they did not have any relatives, and the packing would be their responsibility. When the taxi came a couple of hours later, we saw that their belongings had been placed into five black refuse sacks and taken with them to the new home. Although the taxi was suitable for taking the person in their wheelchair and a member of staff they knew accompanied them, the provider had not made suitable arrangements for their belongings to be transported in a respectful manner.

The home was not maintained in a way that promoted people's sense of well-being. One person told us "The place has been heading south for a long time. It's not clean and not particularly hygienic. If I was looking for somewhere, this would not be my choice."

People's comfort was not always maintained. For example one person was in their wheelchair with their feet on the ground, with socks but no shoes. They had a sling (used for moving and handling) around their waist and under their arms. The sling remained on whilst they were supported to eat their dinner. We observed that they tried to pull off their jumper, but this was hindered by the sling around their body. Staff had not removed the sling so they could eat their meal in comfort.

Staff were not always considerate. For example one person was being helped to eat their meal at the dining table, this was potatoes, baked beans and sausages, the food looked quite dry. They did not have a drink however, the member of staff helping them had a large can of energy drink which they were drinking whilst assisting with the person with their meal. We observed that this person did not get a drink until they were helped back into their armchair in the lounge 45 minutes later.

People's care plans were not always written specifically for each person. People's care plans were very

similar to each other's and one person had another person's name on their care plans which had been crossed out and their name inserted. This meant that staff did not have the guidance that they need to provide people with personalised care and support according to their individual preferences.

The provider had not ensured that people were treated with dignity or respect. This constitutes a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

The provider had made the decision to close the home. Staff were not focussed upon providing care in line with people's preferences nor seeking or acting upon feedback from people nor providing meaningful stimulation. People did not have the opportunity to spend time doing things they enjoyed. Staff did not provide the time or resources to enable people to take part in any activities. There had not been any activities recorded in people's care notes since 22 September 2017, when the provider gave people notice to leave as they were closing the home. People and staff sat in silence in the lounge area.

We observed that people who used the service and staff were emotional. Staff told us they were upset about the home was closing. Staff were reluctant to provide people's care and looked to each other to do this rather than taking responsibility and therefore people were at risk of not receiving their care and not receiving care in line with their preferences. For example one member of staff had to be reminded many times by other staff to keep the lounge area supervised. There were only seven people in the home, with five staff to provide the care; the provider, the deputy manager and three members of care staff, yet people still did not receive their care.

People had plans of care in place to provide guidance for staff in meeting their care needs. However, staff did not always follow people's care plans and therefore people did not always receive the care that they needed. For example staff did not provide the care as planned for one person as they did not ensure they had pressure relieving equipment in place when they used their wheelchair, or have their foot plates on the wheelchair to prevent them from falling out, or have enough to drink to remain hydrated.

One person described how disappointed they were with the service. They told us "I can't have a bath because the bath is broken. The whole thing is a farce. When I first came here I was promised as many baths as I like, now I am lucky if I get one at all. I can have a shower, but this is upstairs; staff are not exactly queuing up to take me through the assault course to get upstairs to have a shower. Needless to say shower nights became fewer and fewer."

The provider did not ensure that people received care that met their needs or maintained people's health and safety. This constitutes a breach of Regulation 9 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care

People could not be assured that their complaints would be dealt with in accordance with the provider's policy. We received complaints from families who told us their complaints had not been dealt with appropriately. Families approached CQC because their complaints had not been addressed. We had raised these as safeguarding alerts. The safeguarding investigation substantiated the claims and a protection plan was put into place.

During the inspection people told us they were unhappy. People were being moved out of the home and felt that their voice had not been heard. People told us they were not happy with the food, the cleanliness of the home or the availability of a bath. The provider had not taken time to speak with each person to listen to

their complaints.

The provider failed to have a system to record and respond to people's complaints. This is a breach of Regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

There was no registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider failed to have adequate oversight of the management of the home. Since the registered manager left in July the provider had not ensured that people received safe care or care that met their needs. Although they had appointed a manager they had failed to ensure that the manager had the skills, knowledge and experience to manage the home. They had not followed their own recruitment procedures to employ the manager; they had taken the manager on the recommendation of friends at their church.

The provider failed to keep people safe. From July 2017 and whilst the new manager was in post, relatives and staff had raised their concerns about the poor level of care being provided. For example people not receiving their medicines, continence care, pressure area care, adequate food and drink or safe moving and handling. Staff had not got the confidence in the manager or the provider to report their concerns and did not feel these would be dealt with appropriately. Staff contacted outside agencies for assistance to keep people safe. The provider had not supervised the manager or staff to ensure they were following the providers' policies and procedures. The local authority quality monitoring team identified that the manager was not aware of the policies and procedures and were not following any structure to provide care or supervise staff. They raised a safeguarding alert; the safeguarding investigation was substantiated. The manager subsequently left the home.

The provider employed a consultant to carry out a full quality monitoring assessment of the home. Their report did not identify that staff were not following the provider's policies and procedures. The provider's action plan reflected the quality monitoring report that they had commissioned which suggested there were no serious concerns. The provider had not carried an appropriate assessment of the quality of the care provided at the home and missed the opportunity to identify where actions needed to be taken to improve people's care and safety. The shortfalls in the quality of care and support that the home provided to people were clearly evident to other outside agencies but the provider failed to acknowledge the significance of these concerns.

The provider had failed to identify that staff were not carrying out fire safety checks or safe food handling. The local authority made referrals to the fire safety officer and the environmental health officer. They also referred the home to the care home pharmacy team and the manual handling assessment team. The provider required daily guidance and support from the local authority to change practice and maintain safety as they were unable to implement the changes required or monitor them to ensure they were embedded.

The local authority met with the provider to explain that due to all of the concerns and substantiated safeguarding alerts that they were placing a suspension on the home from 22 September 2017. This meant

that the local authority would not commission the home to admit any new people. On 22 September 2017 the provider emailed CQC to say they intended to cancel their registration, however, to date we have not received an application to cancel their registration. On the same day the provider told the local authority they intended to close the home.

From this point the multi-agency home closure procedure was activated. This means that the safeguarding authority, the local authorities that commission care and CQC work closely to ensure that all people remaining in the home are kept safe and that they are assisted to find new homes.

The provider had admitted two people who had recently moved from another home that was closing. Within weeks of them arriving they gave them notice to leave as they too were closing. One person told us they were feeling anxious about their future as they had not found a home where they could settle.

After a discussion between CQC and the provider, the provider moved into the home to provide constant management oversight in the home. They told us "I take full responsibility, I am acting as the manager, but I understand that staff know people using the service better than me."

People were unhappy with the way the home had been managed. One person told us "If it [the home] had been a ship, it would have hit the rocks." Staff were also unhappy, one member of staff told us "It's disgraceful, it's not fair, and it's all about money with them [provider]."

The provider and registered manager failed to ensure that there were sufficient systems and processes in place to assess, monitor, mitigate risk and improve the health, safety and welfare of people using the service. This constitutes a breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people received care that met their needs. Regulation 9 (1) (a)(b)(c)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were treated with dignity or respect. Regulation 10 (1)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was reasonable to mitigate known risks to maintain people's health and safety. Regulation 12 (1) (2b) The provider did not ensure that people maintained people's health and safety. Regulation 12 (1) (2b) There was a continued risk that people were not receiving their prescribed medicines. Regulation 12 (1) (2g) There was a continued risk that people's food may not be stored correctly, that safety procedures in the event of a fire and safe moving and handling were not embedded into practice. Regulation 12

(1) (2h)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not follow their systems to safeguard people and they did not protect people from the risks of harm. Regulation 13 (2) (2) (3)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure that people's nutritional and hydration needs had been met. Regulation 14 (1)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to have a system to record and respond to people's complaints. Regulation 16 (1)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that there were sufficient systems and processes in place to assess, monitor, mitigate risk and improve the health, safety and welfare of people using the service. Regulation 17 (2a and b)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure that the manager had the qualifications, competence, skills or experience to manage the home. The provider failed to take suitable steps to ensure the manager was of good character. Regulation 19 (1 a and b)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that there were enough staff deployed to meet people's needs. Regulation 18 (1) The provider had not ensured that staff had received the support and training they required to carry out their roles. Regulation 18 (2a)

The enforcement action we took:

We imposed an urgent condition on the registration to prevent any new admissions without the written permission of CQC.