The Lindens (Stoke Hammond) Ltd

The Lindens Care Home

Inspection report

Stoke House
Stoke Road
Stoke Hammond
Buckinghamshire
MK17 9BN

Tel: 01908371705

Date of inspection visit:
25 January 2022
02 February 2022
03 February 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Lindens is a residential care home providing accommodation and personal care to up to 60 people. The service provides support to older people. At the time of our inspection there were 56 people using the service.

The Lindens accommodates people across three units, which includes the main house and two wings. People have their own ensuite facilities. The home have three double bedrooms available to couples or family members who wish to share. The service have a large dining room, separate smaller dining area and a variety of sitting areas throughout the home.

People's experience of using this service and what we found

Risks to people were not mitigated and the safeguarding policy and procedures did not safeguard people. Medicines were not always given as prescribed and guidance was not provided for when "As required" medicines were to be administered.

Whilst the service was clean and hygienic, the service did not work to government guidance in relation to wearing personal protective equipment (PPE).

Staff were not suitably recruited, and the registered manager had no oversight of staff inductions, training and supervisions to assure themselves that staff were suitably trained and supported for their roles.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Person centred care was not always provided, and people's preferences was not taken into account in relation to their needs, which included decisions on visiting.

The service was not effectively managed and monitored to ensure safe and effective care was provided. Policies were not developed in line with national guidance and best practice to support staff in the delivery of care. Records were not suitably maintained, accurate and fit for purpose.

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 good (6 March 2019).

At our last inspection we recommended that the provider seeks support from a reputable source about the

record management of controlled medicines. We also recommended the service seeks support from a reputable source regarding good governance and quality assurance processes. At this inspection we found record management for controlled medicines had improved. However, good governance and quality assurance processes were not effective.

Why we inspected
We undertook a focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about visiting arrangements. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with visiting arrangements, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well- led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Lindens 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 safe care and treatment, safeguarding people, recruitment processes, consent, notifications and governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Lindens 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 included checking the provider was meeting COVID-19 vaccination requirements. 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
The inspection was carried out by one inspector on day one and two inspectors on the second and third day. An Expert by Experience carried out telephone calls to relatives on 26 January and a second Expert by Experience assisted on site on day three of the inspection to obtain people's view of the service. 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 Lindens 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 Lindens is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection :
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was in the process of completing their Provider Information Return at the time of the inspection. This is information

we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. The completed form was received within the required timeframe, this was after the inspection and was therefore not used to plan the inspection.

During the inspection
We spoke with 11 Relatives and 10 people who used the service about their experience of the care provided. We spoke with three care workers, one team leader, two senior care supervisors, administration staff, assistant manager, the registered manager and the provider. We spoke with three visiting professionals.

We observed lunch and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records relating to people's care which included, multiple medicine records and 12 care plans. We reviewed seven staff recruitment files and a further four staff files to review supervision and training records. A variety of records relating to the management of the service, including fire, health and safety, accident/incident reporting, safeguarding, audits, policies and procedures were reviewed, and others were requested.

After the inspection
We sought clarification from the provider to validate evidence found. There was a delay in the registered manager responding to our request for information and in some cases the requested information was not provided.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated Good. At this inspection this key was rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
● Risks were not always identified and where they were, they were not mitigated. Risks to people from the use of bedrails had not been identified, or assessed. Where risk in relation to falls, choking, behaviour that caused distress, pressure damage and medical conditions had been identified, these had not been mitigated.
● One person had recurrent falls and whilst action was taken to mitigate the risk there was no risk management plan in place . The person presented with distress. There was no guidance for staff on how to manage those episodes of distress. A mental health and behaviour risk assessment was in place which identified the risk, but no management plan was in place to mitigate the risk and provide guidance to staff on how to support the person when distressed.
● The fire records showed the weekly and monthly checks were not carried out at the required frequency. The fire test records showed the last weekly fire test check was completed on the 4 January 2022, which was not weekly. The fire risk assessment was overdue for review since November 2021. Whilst the records showed an unplanned fire drill had taken place in January 2022, planned monthly fire drills had not taken place since September 2021 which was not in line with the providers own guidance. We saw a door wedge in use in the kitchen. We were told this was because the door closure was not working properly. However, this had not been reported to maintenance and the risks around the use of the door wedge had not been mitigated.
● A radiator in the dining room was hot to the touch and uncovered. The registered manager advised this was previously covered and was being addressed but there was no record to indicate how long it had been uncovered. Therefore, service users were placed at risk of burns.

Safe care and treatment was not always provided. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Accidents and incidents had been documented and showed they were responded to appropriately. However, there was no records to show what the service had learnt when they had happened.

Using medicines safely
At the previous inspection a recommendation was made that the provider seeks support from a reputable source about the record management of controlled medicines. At this inspection we found controlled medicines were appropriately managed and records accurately reflected the controlled medicines in use.

● The provider's medicine policy reviewed in June 2021 was not developed in line with best practice guidance on "Managing medicines in care homes". The policy made no reference to how topical creams were to be recorded and there was no guidance included on the administration of "as required" medicines.
● In two of the medicine administration records viewed, we saw those individuals were prescribed "as required" medicine such as 'Lorazepam' and 'Haloperidol'. The lorazepam was given frequently for restlessness and the haloperidol was given for anxiety and or restlessness, with no guidance on what was perceived as anxiety for that person, to ensure the medicine was consistently given for what it was prescribed for. The British National Formula (BNF), does not indicate that either of these medicines are to be administered for restlessness.
● An individual whose medicine record we reviewed was prescribed morphine sulphate "as required", and no instructions were provided as to why and when this would be administered as opposed to other pain relief which they were also prescribed. A person was prescribed Glucogel. The instructions were to use as directed, with no directions given on its use.
● Other people were prescribed topical creams, regularly or as required. A number of people had more than one topical cream prescribed. There was no guidance for staff as to where the topical cream was to be applied. The medicine administration records showed gaps in administration and topical creams were not consistently administered for what they were prescribed for.
● Risks relating to medicines were not identified. People prescribed anticoagulant medicines, placed them at higher risk of excessive bleeding and bruising. The risks around this had not been considered or mitigated. Cetraben cream which is flammable was in use. A general risk assessment was in place for the use of creams, but this was not specific to creams which were flammable and not related to individuals who were using the cream.
● People had unrestricted access to medicines which were not prescribed to them. During the inspection we observed the medicine trolley was left unattended and insecure. We were informed this was because the lock on the medicine trolley was broken. On further exploration it was confirmed that the lock to the medicine trolley had been broken since November 2021. Whilst a new lock was ordered and received it was not fitted in a timely manner. This posed risks to people living in the home with dementia and were independently mobile.

Safe medicine practices were not always promoted. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

● The provider took immediate action to address this and the replacement lock was fitted.

● Systems were in place to record medicines received, administered and disposed of. Stock checks of medicines took place and temperature checks were maintained of the medicine cupboard, fridge and the room medicines were stored in.
● Staff had their competences assessed to administer medicine. They were trained in medicine administration, although the training had not highlighted to them, they were not working to best practice.

Systems and processes to safeguard people from the risk of abuse
●The provider's policy on abuse and safeguarding adults dated 22 June 2021 was brief. It indicated that in the first instance, an allegation or suspicion of abuse should be reported to a Senior Carer or the Manager. It outlined this was to allow every opportunity to investigate and take appropriate action and all parties are given the opportunity to act professionally and with propriety. This is not in line with Buckinghamshire multi-agency policy dated March 2021, which states "Any individual that becomes aware of an adult at risk as a result of abuse or neglect must refer the matter to the Buckinghamshire Council's Safeguarding Adults Team for them to decide the most appropriate way to respond."

● People said they felt safe , some people told us they did not know what to do if they felt unsafe. There was no visible easy read signage displayed in communal areas of the home to inform people of what to do if they felt unsafe.

People were not safeguarded from the risk 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.

● Staff were trained in safeguarding and told us they would report safeguarding concerns to the seniors and registered manager for them to act on.
● The registered manager informed us in response to the draft report that notices are on display in bedrooms to inform people what to do if they felt unsafe.

Staffing and recruitment
● Safe recruitment practices were not promoted. The provider's recruitment and selection policy dated May 2021 outlined "All offers of employment are made on condition that satisfactory references are obtained in respect of the applicant. One of which must be from their current or last employer. If the references prove to be unsatisfactory, the offer of employment may be withdrawn. (Ideally two references but in exceptional circumstances, one legitimate reference will be acceptable.)." In six of the staff files viewed only one reference was obtained. For three staff, the only one reference on file was from a work colleague of their previous employment as opposed to from their previous employer. In one staff file a reference was requested but not obtained and the staff member was already working at the service.
● Providers are required to complete Disclosure and Barring checks on staff prior to them commencing employment. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. In two of the seven staff recruitment files viewed proof of a DBS was not on file or made available to us. In another staff file their DBS showed a previous criminal conviction. However, there was no evidence of a discussion with the staff member regarding the offence and no risk assessment was completed to enable the registered manager to satisfy themselves any risks around the conviction was mitigated.
● Prospective candidates were asked to complete an application form and attend for interview. The application form and record of interview were brief and incomplete. Neither evidenced that gaps in employment were considered, explored and satisfactorily addressed.
● Staff had completed health questionnaires, however, where medical conditions were identified the risks around those were not identified and mitigated.

Recruitment procedures were not operated effectively to ensure fit and proper staff were employed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had an established staff team who demonstrated a good understanding of people's needs. Staff felt the staffing levels were sufficient. Staff commented "Staffing levels are good", "Staffing levels are sufficient, and we rarely have to use agency staff." The registered manager confirmed in response to the draft report that the service never use agency staff, which promotes continuity of care.
● At lunchtime we observed lunchtimes were well organised. However, we saw one staff member supporting two people to eat their meal at the same time and another staff stood over people whilst supporting them. We shared our observations with the registered manager.

Preventing and controlling infection

● We were not assured that the provider was using PPE effectively and safely. On our arrival at the home on day two of our inspection we saw a number of staff were not wearing masks. The registered manager told us they had made this change on the previous Monday and staff were still expected to wear them in the morning and when doing personal care but could remove them in the afternoon. The provider told us masks were a barrier to communication with people and the decision to take masks come off in the afternoon was to promote communication. The team meeting minutes for the 1 February 2022 stated, "Following a review, it has been decided that masks only need to be worn for close personal contact, in the coffee shop when visits were taking place and in transport." We asked to see the risk assessment to support their decision not to work to government guidance on personal protection equipment in care home. A risk assessment had not been completed as the registered manager stated, "It was only guidance." However, they immediately revoked their decision and informed staff to go back to wearing masks. Throughout the inspection we saw some staff wearing the mask off their nose, despite several reminders from us to wear it correctly and team meeting minutes for September 2021 showed the decision was made then too for staff not to wear masks.

● We were not fully assured that the provider was accessing testing for people using the service and staff. In team meeting minutes dated 9 June 2021, it was recorded that new guidance recommended COVID testing should be carried out 4 weekly for residents and weekly for staff. However, the registered manager had made the decision to carry out testing for staff every two weeks as opposed to weekly in line with guidance at that time. The registered manager confirmed in response to the draft report, they had been following government guidance relating to Covid-19 testing in care homes but the confusion was due to, "An inexplicable error in the recording of the minutes of the meeting shown to inspectors."

● 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 admitting people safely to the service.

● 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 not assured that the provider's infection prevention and control policy was up to date .

We have also signposted the provider to resources to develop their approach.

Visiting in care homes

● Relatives gave various comments about visiting arrangement at the service. Comments included, "It was hard to get visits originally, not good for the mental health of dad with the lack of visits, mum became poorly quite quickly and transferred to the hospital, the home told us that if she returned to the home, we would be able to have more visits but she died two weeks ago not returning to the home. Not visiting her because of Covid did not help", "We don't get access very often and would prefer more visits, they (management) did not consult us. They sent information of what was to happen" and "I always used to take (family member) out but not been able for the last 2 years. Visits (the service) have done well. The current situation is, they (the service) have to protect everybody but it is not good for his mental health."

● The providers visitor's policy outlined "Relatives and friends of residents may visit at any time although the Home does ask them to respect mealtimes, 12:00 – 13:30 and 16:30 – 17:30, when the residents enjoy their lunch and tea. In the evening, it is requested that visitors leave by 19:30".

● We found the provider's approach to visiting did not align to government guidance. At the time of our inspection, inside visits were permitted but only for a duration of 30 minutes. We had received concerns about the provider not allowing relatives to have Essential Care Giver Status, a view of the provider's policy confirmed they were not working in line with government guidance relating to Essential Care Givers. This

meant the provider failed to consider what impact their decision had on peoples' emotion well-being. We have reported further on this under the Well-Led section of this report.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

● The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

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 as requires improvement. At this inspection the rating has changed to Inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At the previous inspection we recommended the service seeks support from a reputable source regarding good governance and quality assurance processes. Whilst an auditing system has been introduced, auditing was not effective and did not pick up the issues we found.

●The providers policy on risk assessment outlined that the registered manager had overall responsibility for risk assessments. However, the registered manager failed to recognise risks or implement robust monitoring to identify risks, which resulted in unsafe care and treatment.
● The registered manager was unable to demonstrate they had kept themselves up to date with relevant role specific training and practice, to carry out their job role. Policies and procedures relating to medicine, safeguarding, recruitment, supervision, quality monitoring were brief and not developed in line with national guidance and best practice.
● The provider did not have effective systems in place to make sure staff were suitably recruited, trained, inducted, and supervised. Whilst staff told us they felt supported and received inductions and training, the registered manager had no oversight of inductions, training and supervisions. Recruitment files showed induction records were not up to date. Specific tasks were delegated to staff such as medicine management, training, inductions, care planning and risk assessments. However, the registered manager had not assured themselves staff were suitably inducted, trained and supervised for the roles and they had no oversight of the tasks that had been delegated to staff.
● Staff had not received regular supervision in line with the provider's policy on supervision. The supervision policy indicated staff should have four one to one supervisions per year. The staff files viewed showed this was not taking place with staff files indicating for some staff their last recorded supervision was in 2019 and 2020. There was no records to show how staff with delegated responsibilities such as carrying out needs assessments, risk assessments, mental capacity assessments were effectively supported.
● The registered manager told us the staff member who completed the moving and handling training and competency assessments of staff was not signed off as a moving and handling trainer. They had not considered the risks associated with this practice and took no action to seek the appropriate training. The service supported people with dementia, on end-of-life care, and with behaviours that challenged. There was no record that specialist training had been provided to staff to support them in their role. The registered manager confirmed in response to the draft inspection report that specialist training had taken place in 2018 and 2019, however they had not sought updates due to the pandemic.

●The providers quality monitoring policy outlined their policy statement but then failed to specifically outline how quality would be monitored. It indicated audits and analysis are carried out at specific intervals with no detail on the aspects of care and delivery audited or frequency of those audits. We viewed various audits which covered staff files, infection prevention and control (IPC), medicines and accidents and incidents. There was no analysis of the data collected in order to pick up on any trends or emerging patterns in order to make further improvements to the service. The registered manager confirmed in response to the draft inspection report they analysed the audit summaries. However, these failed to identify and address the issues we found.

● People's care records were not always contemporaneous, accurate or complete. People's fluid charts were not totalled to provide an accurate record of fluids taken. There were gaps in other records such as turning charts, medicine administration records and personal care charts. A person's record referred to them as 'behaving terribly' and another person's record referred to them as being 'verbally abusive when not receiving attention'. One person's records indicated they had an allergy to a medicine. In updated records this was not reflected.

● Other records such as review of risk assessments were not signed by staff. Accident and incident records were at times illegible, incomplete and failed to indicate if a risk assessment was required. Sections of care plans, such as hobbies, interests, life histories, daily care needs, and preferences were blank or limited information was recorded to ensure people's needs were identified and met. Fire records showed gaps in the required checks.

● The provider had a 'Specific Covid-19 Resilience and Contingency Plan' however, this had not been completed. This meant there were no systems in place to ensure the service could continue to provide care and support to people in the event of another outbreak of Covid-19.

Quality assurance and monitoring systems were not effective as audits were not able to pick up the concerns we had found. Records were not suitably maintained to assess, monitor and mitigate risks. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us the service was well managed and the provider regularly visited the service. They felt able to raise concerns with management, who always gave them advice. A staff member commented "[Name of provider] is very good, approachable and I feel able to take any concerns to them for advice on."

● The registered manager is required to inform us of incidents such as an injury to a person, any incident which is reported to the police and safeguarding incidents. From the records viewed, we saw the required notifications were not made in respect of police intervention, an accident which resulted in a person being admitted to hospital and two safeguarding alert referrals that were made to the Local Authority.

The required notifications were not made to the Commission. This was a breach of Regulation 18 (Registration Regulations 2009) – notification of other incidents.

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

● People and staff were not able to regularly provide their views to influence the running of the service. Meeting minutes showed staff team meetings had taken place in June 2021, January and February 2022. A separate meeting had taken place with housekeeping staff in July 2021. A resident meeting had taken place in June 2021. The meeting minutes indicated the meetings were meant to be held monthly, which was not the case.

● The provider was not working to the Mental Capacity Act 2005. The provider's policy titled 'Mental

Capacity Act strategy and procedure' was brief and did not outline the strategy or the procedure on its application. Where people lacked mental capacity to make an informed decision, or give consent, we found the provider did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Decision specific mental capacity assessments were not completed for people who lacked capacity in relation to their care. The registered manager confirmed they had not consented with people or undertaken mental capacity assessments at the time of imposing restrictions on visits, carrying out Covid-19 testing and in the use of surveillance cameras.

● In one person's records we saw a lap belt was in use to mitigate their risk of falling. A DoLS application had been made but not yet approved. However, there was no mental capacity assessment or best interest decision record to support the practice of using the lap belt and the person was unlawfully restricted.

● Another person had an emergency DoLS approved for seven days. However, that had expired, and the registered manager had not followed it up with the Local Authority to ensure the person was not being unlawfully deprived and restricted. The registered manager confirmed in response to the draft report that the DoLS team had confirmed the service was not required to resubmit a DoLS referral when the emergency one had expired.

People were not consented with on their care and the service did not work to the principles of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for Consent) 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

● Person centred care was not always promoted. People who had capacity were not consulted with on the visiting arrangements for the home, which included the provider's decision not to allow visitors on Christmas day, boxing day and access for Essential Care Givers was not provided. At the time of the inspection 30-minute visits were still in operation and visits were only taking place in the coffee shop area set up for that purpose. Notices on the front door stated the home was still closed to visitors.

● In the resident meeting minutes dated 2 June 2021 it was recorded the manager updated residents on the latest corona virus restrictions, letting them know that they are now allowed two visitors inside to visit. This demonstrated the lack of inclusion of people in these decisions which impacted their well-being.

● The provider did not actively encourage and seek feedback about the quality of care as it relates to care home visits. This was corroborated by emails that were sent to relatives on 2 December 2020 and 8 November 2021. Relatives told us they had not been asked to give their views about visiting restrictions and discussed the negative impact it had on them and their family members.

● Relatives commented, "Visits are difficult since Covid as her (family member) hearing and sight is very poor." When referring to window visits, the relative continued to say, (family member) had to hold a hand-held device which was hard for her and it was pointless as she could not hear me and the speaker was rubbish and I could not hear her, it was pointless as I could not talk to her. She deteriorated and lost all memory of me. Another relative, when referring to Christmas visiting restrictions told us, "This could be our last Christmas with her (family member), we need to sit with her, it is cruel for her not seeing us except for once a week and I don't want her last years for her to be locked away. It is the first time we have not seen her at Christmas. They (the provider) said that they could not accommodate everybody."

● "We received some positive comments about visiting arrangements. This included, "They have done brilliantly in Covid, I can book a half hour visit, visits are settling down now and it was busy when everyone wanted to visit over Christmas time, was not a problem to me that they were closed for visits on Christmas Day and Boxing Day" and "Visiting has not been a problem, instead of standing outside they now use a lounge area."

Person centred care was not provided, and people's personal preferences were not taken into account. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider responded immediately during and after the inspection. They commenced the process of seeking feedback from relatives about current visiting arrangements and Covid-19 testing before they updated their visiting policy. On day three of the inspection the provider held a meeting with a family member to discuss introducing an Essential Care Giver role. They confirmed they had agreed to make changes to the visiting arrangements and would give people the opportunity to nominate an Essential Care Giver.

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 a duty of candour policy (DoC) in place. The policy was developed in line with Regulation 20 and at the time of our visit there were no notifiable incidents that applied to the Doc.

Working in partnership with others

● The service worked with relevant health professionals. We spoke with three health and social care professional during our visit who gave positive feedback about how the service worked pro-actively with them to get good health outcomes for people who used the service.

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 18 Registration Regulations 2009 Notifications of other incidents The required notifications were not made to the Commission. Regulation 18 (1) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person centred care was not provided, and people's personal preferences were not taken into account. Regulation 9 (1), (3) (d)

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 People were not safeguarded from the risk of abuse. Regulation 13 (1), (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure fit and proper staff were employed.

Regulation 19 (1) |(a), (2).

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 11 HSCA RA Regulations 2014 Need for consent People were not consented with on their care and the service did not work to the principles of the Mental Capacity Act 2005. Regulation 11 (1), (2), (3).

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not promoted, this was because Risks were not always identified and where they were, they were not mitigated. Regulation 12 (1), (2), (2)(a), (2)(b), (2)(d), (2)(e), (2)(g), (2)(h).

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and monitoring systems were not effective as audits were not able to pick up the concerns we had found. Records were not suitably maintained to assess, monitor and mitigate risks. 17(1), (2), (2)(a), (2)(b), (2)(c).

The enforcement action we took:

We served a warning notice.