# Selly Park Healthcare Limited

# Selly Park

## Inspection report

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30 January 2019
31 January 2019

Date of publication:
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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service: Selly Park is a care home that is registered for 50 people and was providing personal and nursing care to 38 people at the time of our inspection.

People's experience of using this service:
Not all risks to people were being managed effectively to ensure people's safety. Safe moving and handling practice was not always followed. Not all people received their medicines as prescribed.

There was not always enough staff on shift to care for people. People did not always receive the support they needed at meal times.

People were not supported by staff whose training was consistently effective and always gave them the skills and knowledge required.

People were not supported in a consistently caring way. While some interactions were kind and caring and positive examples were seen, we saw staff were not always consistent with this support.

People had access to some leisure opportunities and activities. Improvements could be made to the opportunities available.

The registered manager understood her responsibility under the Mental Capacity Act 2005 (MCA). Staff were recruited safely and understood their responsibility to protect people from the risk of harm and report their concerns.

The provider had quality assurance and governance systems. These were not effective in identifying the areas of improvement required within the service.

We found the provider was not meeting the regulations around safe care and treatment, staffing and good governance.

Rating at last inspection: At our last inspection in January 2017 (report published in April 2017) we rated Selly Park Nursing Home as Requires Improvement.

Why we inspected: This was a planned inspection which took place on 30 and 31 January 2019

Enforcement : Full information about CQC's regulatory response to the more serious concerns found and appeals is added to report after any representations and appeals have been concluded.

Follow up:  As we have rated the service as inadequate, the service will be placed 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 act 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.

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.

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.

## 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 effective?**

Requires Improvement

The service was not always effective

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Details are in our Effective findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring

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Details are in our Caring findings below

**Is the service responsive?**

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

# Selly Park

**Detailed findings**

## Background to this inspection

The 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.

Inspection team: The first day of our inspection visit on 30 January 2019 was carried out by an inspector, an assistant inspector one specialist advisor and one 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 service. A specialist advisor is a qualified health professional. Our specialist advisor had expertise in nursing care. On the second day of our inspection one inspector returned to complete the inspection.

Service and service type: Selly Park is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and care of the service provided.

Notice of inspection: The inspection was unannounced on day one of our visit. We told the registered manager that we would be returning the next day to complete the inspection.

What we did:
We reviewed information we had received about the service since their registration with us (CQC). This included details about incidents the provider must notify us about, such as alleged abuse. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection visits, we reviewed eight people's care records to ensure they were reflective of their needs, and other documents relating to the management of the service such as quality audits, people's

feedback, meeting minutes and four staff recruitment files.

During our inspection we spoke with 15 people living at Selly Park and three visitors or relatives of people who lived there. We also spoke with the registered manager and operations
Manager. We spoke with 12 staff including nurses, care staff, housekeeping and catering staff and one visiting healthcare professional.

Some people were not able to tell us what they thought of living at the home; therefore, we used different methods to gather experiences of what it was like to live there. For example, we observed how staff supported people throughout the inspection to help us understand peoples' experiences of living at the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

Inadequate

# Is the service safe?

## Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

- Not all risks to people were being managed effectively to ensure people's safety.
- We found that pressure mattresses were in place for a number of people to help prevent sore skin. However, staff did not know how to set these to the correct settings and how to carry out safety checks. During our inspection we saw that mattresses were on the wrong setting. We found that this concern had been raised by staff in a clinical meeting in September 2018. However, the provider had failed to act in a timely way to ensure staff knew what to do to prevent risks to people.
- We saw that staff did not always follow safe moving and handling processes when supporting people. We saw two incidents where the brakes on wheelchairs were not applied during a moving and handling transfer. This practice puts people at risk of injury.
- Risk assessments were in place to reduce the risks to people and guidance was provided for staff to help them reduce these risks. However, they were not always reviewed following an incident or changes in people's needs.
- The work place fire risk assessment which is an assessment of measures in place to keep the home safe and prevent the risk of fire, had not been kept under review. There had been significant staffing changes, changes in occupancy levels and a time lapse since the last review of fire safety. However, this had not alerted the provider to review their assessment and this has the potential to put people at risk of harm.

The evidence above supports the failure to ensure that risks relating to the safety and welfare of people using the service are assessed and managed and was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Using medicines safely

- Not all medicines were managed safely and in accordance with best practice.
- The medicine administration records charts showed that some people had not received their medicines as prescribed. We saw that there were significant shortfalls in the completion of records for a number of people to confirm that barrier cream to prevent tissue damage had been applied as prescribed. We were not able to determine if people had received the creams and staff had failed to sign or if people had not received their creams as prescribed.
- Some people received their medicines covertly and this had been agreed by the GP. The protocol did not indicate that a pharmacist had been consulted as to the suitability to give the prescribed medicines in this manner. Adding medicines to food and drinks may also affect the active ingredient of the medication or how they are absorbed if more than one tablet is taken together.
- Some people required medication 'as and when required'. The protocols for staff to follow when giving these medicines lacked detail. For example, the records did not indicate whether people could verbalise

that they were experiencing pain or what non-verbal behaviours were identified for those that were unable to verbalise when experiencing pain/discomfort.

The evidence above supports the breach of regulation 12 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014

● We observed part of the administration of medicines during the morning, in preparation, staff observed safe administration and in addition checked the medicine was in date. Staff explained to people what each medicine was for. When satisfied that the medicines had been taken all items used to support the administration was cleared away. The whole process was unhurried.
● Medication was stored and disposed of safely.

Staffing and recruitment
●There was not always enough staff to support people and meet their needs and keep them safe.
● The registered manager told us they used a dependency tool to determine what safe staffing levels should be. The registered manager told us that they had not always been able to provide the minimum number of staff to keep people safe. Staff told us and records confirmed that there had been shifts when there were only four or five care staff were on duty.
● We saw that people were left for long periods of time in communal areas without staff available to intervene if people requested support or if a person was at risk of harm. We saw a person who used a wheelchair to mobilise stood up from their wheelchair, the brakes were not applied and the person fell back into the seat. Another person with known health risks to their safety was left unsupervised for long periods of time. We saw that it was taking staff until lunchtime to complete people's morning care routines. We saw people who needed support to eat their meals did not get the support they needed.
●Staff told us that they felt under pressure and rushed in their role. They told us that current staffing levels were not sufficient to meet the needs of people. A staff member told us, "It is the lowest staffing levels that I can remember and we have people now with higher care needs." Another staff member told us, "We don't have enough staff but we do our best."
● We were told by the registered manager that they had received two recent complaints from relatives. They raised concern about delays in their family member receiving their care.
●The registered manager told us that they were currently experiencing a difficult time with staff shortages including sickness, staff dismissal's and annual leave. They told us that they were using agency and were balancing the shift with permanent and agency staff to minimise disruption to people. Despite these measures we found that there were not sufficient numbers of staff to meet the needs of people and keep them safe.

The evidence above supports the failure to ensure that sufficient numbers of staff were deployed; this was a breach of regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014

●Following our inspection, the registered manager told us that the provider had authorised an increase in staffing levels.
●Staff had been recruited safely to ensure they were safe to work with vulnerable people.

Preventing and controlling infection
●There were infection control audits in place. However, there was no system in place to ensure that these

were effective and issues raised dealt with.
●We saw that an audit in September 2018 had identified that a system was needed for the cleaning of people's wheelchairs. However, the registered manager confirmed to us that this had not been implemented.
●The records in people's bedrooms had a chart to record monthly mattress checks. Checking for any damage is an important infection control measure as a damaged compromised mattress cover leads to a contaminated core and is a major convector in the spread of health-care acquired infections. We saw that regular checks were not completed. For example, we saw that for one person the last recorded date was October 2018.
● During our inspection there was a mal odour in parts of the home and the registered manager told us that this was being dealt with.
●Staff told us that they had attended infection control training and the home has an infection control policy that they can refer too.
●We saw that staff used gloves and aprons appropriately, for example when delivering personal care.

Learning lessons when things go wrong
●The provider had a system in place to record accidents and incidents. No analysis of accidents and incidents had taken place since November 2018, so themes and patterns had not been identified. We saw that an incident took place in January 2019. However, no investigation and analysis of the incident had taken place to ensure that the safeguards in place to prevent further incidents were appropriate and ensure that any risks to the service user were mitigated.

Systems and processes to safeguard people from the risk of abuse
● The provider had safeguarding systems in place and all the staff we spoke with had a good understanding of what to do to make sure people were protected from harm or abuse. One staff member told us, "If someone was not being treated properly I would report it to the manager. I am confident that they would take action and report it to the local authority and to CQC."
● People who could tell us told us that they felt safe. One person told us, "Definitely. The staff are nice, and I get on well them. I am quite happy."
● A relative told us, "At the moment, yes I feel she is safe. If there was anything wrong, I would look you in the eye and say I am not happy with this or that".
● We saw that people were often left for long periods of time in communal areas without staff around to minimise any risks to people's safety.

Requires Improvement

# 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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● We received mixed comments from people about the staff. Most people told us that on the whole, staff had the necessary skills to do their jobs, but the quality of care wasn't consistent and was dependent on who was assisting you. Some people told us that they were generally unhappy with the agency staff supporting them because they felt they did not know their needs. One person told us, "The staff are alright if they are regular staff. Agency staff don't know anything about you".

●Staff told us and records showed that staff did not receive supervision sessions in line with the provider's policy. This means that opportunities were missed for staff to reflect on their practice and develop their knowledge.

● Most Staff received training which was relevant to people's needs. However, not all training was effective. For example, care staff did not have effective knowledge around the Mental Capacity Act 2005 (MCA). We saw some moving and handling practice that did not ensure safe practice was followed. Records of training were not kept up to date. However, these were sent to us after our inspection to confirm what training had taken place. These showed training was still required for staff in key areas such as safeguarding and fire safety.

The evidence above supports a failure to ensure staff received, support, training and professional development to be able to fulfil their role effectively. This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●A staff member told us that they had received training to maintain their clinical knowledge. For example, they had recently attended training on the management and prevention of sore skin. They told us that care staff were very good at alerting them to any signs of sore areas. Another staff member told us that they had completed training on catheter care and a district nurse would be providing some specialist training in relation to people's care needs,

● An agency member of staff confirmed that they had received an induction when they first worked at the home a year ago and this was repeated when they returned to work at the home recently. Records confirmed that staff received an induction prior to commencing in their role.

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

● Not all people received the support they needed at meal times. We saw that meal times were disorganised. A number of people required support in their bedrooms to eat their meal and there lacked a personal approach to how this was arranged. Some people told us that meals and drinks were always cold

by the time staff got to their bedroom. One person told us, "It's never on time. I would say it's 'good food spoilt' because by the time it gets here it's cold. The hot drinks are cold too. When it's bad it's really bad." A relative visiting the home confirmed this. We saw some people were left without support at mealtimes and struggled to eat their meal. When we asked staff about this at the level of support the person now needed was not recorded in their care records and was not being provided consistently to people.

● We received some mixed comments from people about the choices of food. One person told us that they felt that they did not really get the choice of food that they would like to eat. Another person told us, "The food is never quite what you want. I would love a steak or salmon occasionally".

● Where it had been identified that there was a need to monitor people's fluid intake these records were not always maintained. For example, there was no daily target on the chart and amounts taken were not totalled at the end of the day. This meant staff would be unable to accurately monitor that people were receiving the fluid they needed. Poor fluid intake increases the risk of infection.

● We saw some good examples of people supported at meal times. For example, we saw that a member of staff supporting a person in their bedroom raised the bed head up so the person was correctly positioned to eat. They then sat next to the person, described the food being offered, enquired as to the temperature of the food and whether they liked what they were being given. They gently stroked their hand to keep their attention and coaxed them gently to eat, they gave the person plenty of time to finish each mouthful and after the meal the person was given a drink.

● Food was provided in line with people's needs. For example, some people required softened food or a fortified diet and we saw that these were provided.

●People were offered drinks and snacks on a regular basis throughout the day and there were 'hydration stations' situated around the home providing ease of access to drinks.

Ensuring consent to care and treatment in line with law and guidance

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

●Staff we spoke with demonstrated a limited understanding of the MCA and DoLS. Many staff were not able to identify which people living at the home were subject to an authorised DoLS or the reasons for this. Staff lacking in knowledge about DoLS may place people at risk of being restricted unlawfully. At the time of our inspection we saw that the registered manager was in the process of implementing a system so staff would be clear about which people living at the home had an application approved or in process.

●Where people did not have capacity to make decisions, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Records showed that best interest discussions had taken place where people lacked capacity to make decisions and these discussions involved relatives and other professionals when relevant.

● Assessments had been completed and where people lacked capacity, DoLS applications had been made to the relevant authorities.

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

●The home was a converted building that had been adapted and extended to serve its current purpose. We observed that corridors and hallways were narrow and at times this presented problems as passing by

people in these areas was difficult and it was challenging when equipment needed to be moved from one area to another.
●An electronic call bell system was in place and the registered manager told us that plans were in place to upgrade the system. The current system did not have a facility on it that allowed for the monitoring of call times.
●The registered manager told us that there were plans in place to improve the building. For example, a new wet room facility was in the planning process and painting and decoration was also under way.
● People told us they liked their bedrooms and we saw people being able to choose to spend time alone or with others. There were a number of communal areas for people to enjoy.
● There was a range of bathrooms on both floors so people could choose to have a bath or a shower and people could move safely between floors by using the lift.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
●People and relatives told us and care records confirmed that staff supported them to access healthcare services. However, care records were not always well maintained which meant that it was not always clear that people were receiving the care that met their needs and ensured risks in relation to their care were being monitored.
●A healthcare professional told us, "Referrals are made in a timely manner. The referrals are appropriate and advice is always followed and the paperwork is always completed and accessible."
● Staff told us that a handover took place at the start of each shift. A staff member told us that they find them very informative and they feel they have all the relevant information to safely take charge of the shift and to keep up to date with changes to people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Before people were admitted to Selly Park, an assessment of their needs were completed for each person to ensure that the service could meet the person's needs.
●From this assessment we saw that a care plan was developed. We saw that some updating of people's care records was needed to ensure that they reflected people's current needs.

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.

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity

● Our observations showed some inconsistencies in the way staff provided care to people. For example, some staff did not respond to people's request for support in a timely manner. Some staff did not take time to explain to people what was happening, or what they were doing. One person told us, "I think sometimes the staff pretend that they haven't heard you call out." Another person told us that staff were busy doing tasks and don't have time to talk to you. A third person told us staff can sometimes be abrupt They told us staff will say, "You pressed the buzzer, what do you want'?"

The evidence above supports the failure to ensure that service users are treated with dignity and respect. This was a breach of regulation 10: Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014

●We also saw evidence of good care practice. We saw staff provided reassurance to people and offered kind words and reassurance. For example, we heard staff say, "Can I help you with that." and, "Are you comfortable?"

● Most staff spoke about people in a person-centred way demonstrating that they knew people's individual routines, likes and dislikes.

●Staff mostly respected people's diversity and treated people in a kind and caring way. They respected people's individual wishes regarding their lifestyle choices. Staff we spoke with were understanding and knowledgeable about how they might need to adapt their support to best match an individual's cultural and religious traditions and preferences.

Respecting and promoting people's privacy, dignity and independence

●We saw some specific examples where people's personal care needs were not met in a way the person wanted. For example, we saw some people were unshaven. When we asked about this one person told us that they would love a shave but their razor had been misplaced. We saw that there was poor monitoring of people's oral care needs and where care plans were in place to meet these needs they were not being met. This did not ensure that people's dignity was promoted.

The evidence above supports the failure to ensure that service users are treated with dignity and respect. This was a breach of regulation 10: Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014

●Most staff knocked on people's door and identified themselves on entering the room. We did see some occasions when staff walked into the rooms of people to return an item and they did not knock the door or

explain to the person what they were doing.

●People were supported to maintain and develop relationships with those close to them. Relatives told us they were free to visit anytime and always felt very welcome.

● We saw some examples of people's independence. For example, some people helped to lay the tables at mealtimes. Also, some people preferred to spend time in their own room and have their own routines and this was respected by staff.

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

●We saw that people were asked to make some choices about everyday life in the home such as what food and drink they wanted. However, this was not always consistent. For example, we saw that people where not asked where they wanted to sit at meal times. This decision was made by the staff supporting them.

●We received some mixed responses when we asked people if they had been asked their views about the care they received. One person told us, "I have never seen my care plan." Another person told us, "I have not seen the actual Care Plan. I don't get involved in it but if I have any problems I talk to them [staff] about it".

Requires Improvement

# Is the service responsive?

## Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●We saw that there was sometimes a lack of consistency in the information within people's care plans. We saw that care records lacked detail. For example, more information was needed in relation to people's specific health needs, or changes in care needs so it was clear what staff should do to meet these needs. There was a lack of information about how people who could not communicate their needs verbally may express when they were in pain. We saw that when people became anxious or agitated, there was a lack of detail to inform staff how to support them. More detailed information would assist staff in preventing people from becoming anxious or agitated and guide their response if it did occur. However, staff we spoke with did know how to reassure people when needed and this was confirmed by our observations.

●People and relatives told us that they were asked about their care. We saw care records to indicate that family members were involved in discussions about people's care. There was evidence of families being informed of changes in people's health and this was confirmed by family members we spoke with.

●We observed at times that there were a lack of things for people to do. However, some people told us they were able to find things to do and we saw some people engaged in activities during the inspection, including a craft session which people told us they enjoyed doing. One person told us, "I am quite happy. I am able to get out. I go to the theatre, local pub, and shopping.". The activities co-ordinator told us that they also spent time with people cared for in bed. The registered manager told us they hoped to improve this area and they were in the process of employing another staff member with the responsibility for co-ordinating activities.

Improving care quality in response to complaints or concerns

●People and relatives, we spoke with knew how to complain and felt confident that any concerns would be dealt with quickly. Relatives told us they were kept informed and involved in their family members care.

●There was a "How to make a complaint" information on the notice board. Some people said that they only raised small things and they got sorted out. One visitor said that residents' meetings were held but were not well attended.

●The registered manager told us that they had received two recent complaints about staffing levels in relation to people's care. The record of actions taken by the registered manager were not available for us to see. However, the registered manager told us that they had spoken with the relatives about their concerns.

End of life care and support

●People had end of life care plans in place and these had been developed to show how people wished to be supported at this stage of their life. No one was receiving end of life care at the time of the inspection.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care. Planning and promoting person-cantered, high quality care and support: and how the provider acts on duty of candour responsibility.

- We found that a culture of continuous learning and improvement had not been established in the home.
- This service has a poor history in relation to meeting the regulations. The service has failed to meet the regulations at all our inspections we have carried out since its registration in 2014. Selly Park has been rated as Requires Improvement across four inspections. In February 2016 we carried out a comprehensive inspection and found multiple breaches. In June 2016 we carried out a comprehensive inspection and found repeated breaches and the service was rated Requires Improvement overall. In April 2017 some improvements were noted and although there were no breaches of the regulations the service was rated as Requires Improvement overall for the third consecutive inspection.
- At this inspection we found that the provider had failed to sustain the improvements that had been made at our last inspection. The service has failed to ensure that learning and improvement took place and was sustained so that people benefit from high quality care.
- Incidents had not always prompted learning to take place to improve the quality of the service. For example, no analysis of accidents and incidents had taken place since November 2018 so themes and patterns could be identified and to demonstrate learning from incidents took place to prevent reoccurrence.

A failure to have effective systems and processes in place to monitor and mitigate risks to people was a breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- A range of checks and audits were carried out to monitor the performance of the service and staff. However, we found that these were ineffective. The provider had failed to respond appropriately and without delay when safety concerns were identified. These included concerns with; safe staffing levels, medicine management and the management of risks to people. The details of these concerns can be found earlier in this report.
- The systems in place to monitor care records had not identified failures to comply with the assessments regarding meeting people's needs, which places people at risk of harm.
- There was a lack of action plans in place following most audits. This meant that there was no system to drive forward improvement at the service and to monitor their effectiveness.

A failure to have effective systems and processes in place to monitor and mitigate risks to people was a breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff told us that they wanted to provide people with good quality care, in a way that people wanted their care to be delivered. They told us the current staffing situation had negatively impacted on their ability to do this.
● Following our inspection, the provider took action to improve staffing levels and address some safety concerns. However, this was reactive to our inspection and did not demonstrate proactive management.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●There was limited evidence that people or staff had been involved or engaged on a regular basis in giving feedback to develop the service. People had completed questionnaires and information about their views were displayed in the home. However, there was no analysis of the results or plans to address any areas for improvement.
● People, relatives and staff spoke positively about the registered manager. One person told us, "[Registered managers name] is very nice." Another person told us that the registered manager was, "Approachable". Most people we spoke with told us that they thought that the service would improve if there were more staff.

Working in partnership with others
● The provider worked in partnership with health colleagues, local authority and other community groups as part of ensuring people received a personalised service.
●The registered manager told us that they were committed to improving the service. They told us that the home had experienced a difficult phase with planned and unplanned staff changes that coincided with a quick increase in occupancy levels. They told us that this had impacted on the service and that they were addressing the shortfalls. They had formally reported the staffing concerns to us and had also informed people, staff and family members about the staffing difficulty.
● The registered manager provided us with information that we requested following our inspection.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not always treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risk's to people's Health, Safety and Welfare were not always assessed monitored and mitigated. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed. |

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 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Systems in place to assess and monitor the service were not effective. |

**The enforcement action we took:**

NOP positive conditions