Medincharm Limited

Bourne House

Inspection report

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

Date of publication:
06 October 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bourne House is a residential care home providing accommodation for people who require personal care. The service is registered to support up to 33 older adults and at the time of our first day on site there were 21 people using the service. All bedrooms are single occupancy, and some have ensuite facilities. There are a variety of communal spaces including living and dining areas, adapted bathrooms and outside space.

People's experience of using this service and what we found
People were not being supported safely to have their medicines. Systems were not robust to ensure suitable amounts of medicine were available and stored appropriately and administered safely by trained staff. Risks were not always mitigated and appropriate assessments were not always in place. Current guidance regarding good infection control practise within care homes had not been effectively implemented. Records did not demonstrate that staff had been safely recruited and staff did not have all the training, checks of skill or support to meet people's needs. Processes to ensure sufficient numbers of staff would be available as part of a contingency management plan were not robust. Where incidents, accidents or safeguarding's had happened it was not clear that lessons had been learnt and action to reduce future risk had been taken.

Systems to ensure people's needs were met were not effective as records were not accurate and detailed. There were no clear lines for responsibility, escalating concern and ensuring actions were followed up. We could not be certain that people were receiving the right modified diet, as staff had not received sufficient training in this area. Records did not demonstrate that robust action was being taken for those at risk of weight loss. Systems for oversight and checks of premises and equipment were not being documented and there were a number of shortfalls identified over the course of the inspection by us and the local authority who were supporting the home.

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. Capacity assessments and best interest decisions for people who had been assessed as not having capacity were not recorded.

The home was not being well run. At the time of the inspection, there was no home manager and the nominated individual was onsite dealing with the day to day running of the home. Systems to ensure oversight were not being completed and the actions we asked the provider to take on the initial days of inspection had not been completed when we returned to the home for a third day on site. The provider had not completed an action plan for CQC following the last inspection. We were not assured the provider would take the necessary action to drive improvement, despite the additional daily support of the local authority quality improvement team, or that any improvements could be embedded and maintained.

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
Our last inspection was a targeted inspection where we looked at specific concerns but did not rate the service (published 9 November 2021). The last rating for this service was requires improvement (published 15 February 2021).

The provider was asked to complete an action plan after the last inspection to show what they would do and by when to improve. This was not received.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
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 inspection was prompted in part due to concerns received about a variety of safety issues including staffing levels, staff training, the management of medicines, and the management of the service and provider oversight. A decision was made for us to inspect and examine those risks. The inspection was also prompted in part due to information we received regarding a specific incident following which a person using the service had died. This incident is being reviewed to determine whether a criminal investigation may be needed. This inspection did not examine the circumstances of the incident.

As a result of the above concerns, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective 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 Bourne House 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 the provision of person-centred care; how people are protected from the risk of abuse; how people are protected from risk associated with infection, the administration of medicine and lack of robust risk assessment and management plans; the safe recruitment, training and number of staff to meet the need of the people living at the home; having a suitable environment and equipment; providing healthy diets that meet people's needs; and ensuring the people are supported in line with the Mental capacity act (2005). We found a continued breach in relation to having effective systems of oversight to ensure the home is well run.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Bourne House

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 completed by one inspector.

Service and service type
Bourne House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The provider employed a home manager during the course of the inspection. The provider was legally responsible for how the service is run and for the quality and safety of the care provided.

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. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited the service and reviewed staffing levels and walked around the building to ensure it was clean and a safe place for people to live.

We spoke with three people who used the service and nine members of staff including care workers and auxiliary staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records including five people's full care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were examined.

After the inspection
We continued to review information provided by the provider and the local authority.

Inadequate

Is the service safe?

Our findings

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

At our last inspection (published 15 February 2021) we rated this key question good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not being safely managed. The provider did not have systems for oversight of how people were supported with their medicines. Staff had not had the appropriate level of training or checks of competency.
- People's medicines were not being stored securely. We found that medicines trolleys and the controlled drugs cabinet were not secure. Appropriate checks of the medicine room to ensure it was clean and a suitable temperature were not being completed.
- Robust processes to ensure people's medicines were ordered and disposed of appropriately were not being followed. We found examples were people had not received a new supply before they ran out of their medicine, and a number of medicines which had not been disposed of when they were no longer needed.
- We were not assured that people were consistently receiving their medicines as prescribed. Medicine counts were not always correct, there were gaps in medicines administration records, and these records did not contain accurate current information about people to ensure the right people got the right medicines at the right time. People who required their medicines to be given in a different way, such as in a drink due to swallowing difficulties, did not have the appropriate specialist guidance to ensure this was being safely done.

People were not being safely supported to have their medicine as prescribed. This placed people at risk of harm. This was a breach of regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the initial site visit the provider received additional support from the medicine optimisation team at the local authority. They identified a number of other shortfalls in how medicines were being managed in the home and raised safeguarding concerns on these matters. An action plan was then implemented with the provider.

Preventing and controlling infection

- People were not being protected from the risk of infection. The provider did not have suitable systems of oversight of infection control within the home, including with regard to the management of the risk from Covid-19.
- Effective enhanced cleaning was difficult due to the layout of the home and some areas of the home needed redecorating. Cleaning records were not being completed and cleaning staff often supported shortfalls in the care team and were unable to complete their own tasks.
- The provider was not able to demonstrate they were following the current guidance regarding the testing and vaccination programme for Covid-19. There were no records to demonstrate that regular lateral flow

testing (LFT) had been completed by staff prior to beginning their shift. Staff told us the provider had not asked them to complete these tests on a regular basis or was checking the results with them. On the first day of inspection we were told two staff had a positive Covid-19 LFT result that morning. We raised this with the provider and ensured these staff members were sent home and arrangements were made for staff cover. We could not ascertain whether the provider had been aware of this and were not assured the provider understood the requirements of testing, current isolation guidance and associated risks.

● People who had tested positive for covid-19 were not effectively cohorted from those who had not tested positive and people were free to move throughout the building through the day. Records did not reflect who had a current covid-19 status, and the regular checks of symptoms for both people who had tested positive for covid-19 and those who had not was not being completed. Robust systems for the donning and doffing of PPE and additional hand hygiene were not evident.

People were not being protected from the risk of avoidable infections. This placed people at risk of harm. This was a breach of regulation 12 (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the initial site visit the provider received additional advice from the infection prevention and control team at the local authority and ongoing support from the local authority quality improvement team. However, when we returned for the third day of inspection it was not evident that advice, such as improving ventilation, had been implemented and accurate records of people's covid-19 status were not in place.

● At the time of the inspection only essential visitors were able to visit the home due to an outbreak of Covid-19. The provider told us that window visits could be arranged during this time. Records did not demonstrate that the home had been following the guidance regarding visiting or that families had been effectively communicated with regarding the arrangements and rights to visit their relative or become an 'essential carer'.

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. We found the service did not have effective measures in place to make sure this requirement was being met.

● The provider did not have accurate records of staffs' Covid-19 vaccination status. There was no evidence of oversight of staff who had not received both doses of vaccine or who may be exempt from this condition of deployment. Systems implemented to manage associated risk for those exempt or more vulnerable due to associated health conditions were not implemented effectively. The provider told us they had taken steps to address this following inspection.

Assessing risk, safety monitoring and management

● The provider did not have systems to ensure oversight of matters of health and safety. A member of staff had completed a health and safety assessment and documented areas of shortfall to be addressed but these records had been removed or gone missing. We noted a number of areas where action was required and requested the provider completed a variety of checks across the premises.

● Generic and environmental risk assessments were in place but were not comprehensive in the areas covered and had not been reviewed recently. The provider did not have records to demonstrate systems for assessing and addressing risks within the home were being completed, for example with identifying and removing potential trip hazards.

● People's needs and risks were not always clearly assessed, documented and mitigated. For example, those at risk of weight loss were not being closely monitored. One person was at risk of leaving the home

and managed to leave the home briefly on one day of the inspection. Care plans and risk assessments did not demonstrate that this risk had been mitigated as much as possible. The provider was asked to address these shortfalls.

Risk to people was not being fully assessed and mitigated as much as possible. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Maintenance and checks of equipment, such as lifting equipment and water were in place. However, records were not being clearly maintained to demonstrate provider oversight should action have been required.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider did not have oversight or robust systems to ensure people were kept safe. Actions and learning from safeguarding incidents were not consistently followed up by the provider and there was no evidence that learning was shared with staff.
● Records did not demonstrate that staff had up to date training in this area. It was not clear that the provider had taken the action needed where concerns had been raised by staff. Staff told us they did not feel confident the provider would take action when concerns were raised.
● We asked the nominated individual to report a number of safeguarding concerns, as well as a number of other immediate actions to keep people safe during the inspection. When we went back to the home on the third day not all of these immediate actions had been completed by the provider.

People were not being safeguarded from avoidable harm. This placed people at risk of harm. This was a breach of regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the initial site visit the home received additional ongoing support from the local authority quality improvement team who completed regular checks of the home to ensure people were safe.

Staffing and recruitment
● Records did not demonstrate that robust recruitment was being completed. Records of DBS were not recorded on file. 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. Recruitment records did not demonstrate that robust reference checks with previous employers and a robust interview process had been completed. At the last comprehensive inspection (published 21 October 2019) we reported there was no a sufficiently robust system of oversight to ensure recruitment checks were competed in a timely manner under a breach of regulation 17 (1) (2) (b, c).

People were not being protected from the risks associated with unsuitable recruitment processes. This placed people at risk of harm. This was a breach of regulation 19 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was not enough staff to meet the needs of people living in the home. Throughout the inspection we observed auxiliary staff providing care to people due to staffing shortfalls. The recent covid-19 outbreak in the home had compounded staffing issues. However, there was no evidence that the provider had implemented contingency plans, such as booking agency staff, prior to the inspection. We were not assured the provider had oversight and had considered and directed how staff were deployed within the home during the inspection.

● There was not enough staff trained to provide certain aspects of care. For example, we found evidence that people had received their medicines from staff that were not trained and competent in this area.

People were not being protected from the risks associated with not having enough suitably trained staff to meet their needs. This placed people at risk of harm. This was a breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider acknowledged the challenges of staffing recently and told us they had attempted to book agency staff recently when needed. The nominated individual attempted to fill any shortfalls in staffing with their presence on site. This had meant they had been onsite for a full 24 hours on at least one occasion. We were not assured the provider was proactive in addressing shortfalls and escalating concerns. There was not a robust contingency plan in place for emergency circumstances.

Inadequate

Is the service effective?

Our findings

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

At our inspection (published 15 February 2021) we rated this key question requires improvement. At this inspection, the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- The provider did not have robust independent systems for assessing people's needs prior to admission. The service had admitted two people for short term respite care and relied on information provided as part of the social work assessment. It was not evident that the assessments had been fully reviewed to identify potential risks and these individuals did not have detailed care plans implemented in a timely way following admission.
- The provider did not have systems for ensuring accurate records were maintained and available to ensure accurate assessment of people's needs. For example, weight records were not being consistently completed and daily records lacked detail to enable oversight of any change in needs. Care plans were not rewritten to accurately reflect any change in needs. Handover records did not readily identify specific needs and risk for individuals to ensure people's immediate needs were being met when new or agency staff were working.
- Records and our observation of care being delivered did not demonstrate that people were receiving the care they needed in line with their needs and preferences.

The registered provider did not have appropriate systems to ensure people's care and treatment was appropriate, met their needs and reflected their preferences. This was a breach of regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not always supported with a healthy and balanced diet. We observed the main meals were provided close together and that healthy and varied snacks were not being consistently offered throughout the day. Records and feedback from people indicated this was not solely due to the recent staffing issues.
- Kitchen staff were aware of people who had been assessed by speech and language therapists as requiring a modified diet, such as pureed meals, but had not had any formal training regarding how to create the correct consistency. Menu charts were not being consistently maintained, and we were not assured of the accuracy of these records. It was therefore difficult to be certain people were having the appropriately modified meals.
- Accurate records of people's weight were not being completed. People at risk of malnutrition were identified as needing close monitoring and weekly weights but it was not evident that this was taking place or that any weight records were accurate. Records did not demonstrate that people who had lost weight were being identified within reviews and action and appropriate referrals made.
- Records did not consistently demonstrate that where dietician advice was in place, or where fortified

snacks and drinks were prescribed, that people were receiving these.

People were not always provided with food and drink in line with an accurate assessment of their needs and preferences. This was a breach of regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Records did not demonstrate that suitable checks of equipment and the environment were being completed on a regular basis. For example, we checked a number of sensor mats and call bells and found these to be working on the day. However, there had been a previous safeguarding concern about this and no system of regular checks had been implemented.
● We found a number of environmental shortfalls across the home. A recent health and safety assessment completed by a member of staff had gone missing. We asked the provider to arrange for this to be completed, in addition to other checks including temperature checks of hot water.
● The home was in need of redecorating. Some areas of the home were shabby and difficult to keep clean. There was limited evidence of signage to support people to find their way around the home.

The premises and equipment were not always suitable for the purposes they were being used, properly used and maintained. This was a breach of regulation 15 (1) (c, d, e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the initial site visit the home received additional ongoing support from the local authority quality improvement team who completed checks of the premises and supported the immediate risks to be addressed by the provider.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider did not have robust oversight of people subject to restriction under DoLS. Where people were subject to restrictions, applications for DoLS had been made. However, it was not clear that where DoLS had been granted with conditions, that this had been incorporated into care records. Staff did not have current and accurate information about who was subject to restrictions under DoLS.
● Care records did not demonstrate that people's mental capacity was being considered and best interest decisions were being made and accurately recorded. Based on our observations and records, we were not

assured that people were always asked for consent before being supported.
● Records did not demonstrate that staff had completed training in this area or were confident in their understanding of the MCA and DoLS.

The need for consent was not always considered and recorded in accordance of the Mental Capacity Act 2005 when people were receiving care and support. This was a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider did not have suitable systems to ensure staff had the training, skills and support to complete their role.
● Training records were not being accurately maintained and it was not evident that staff had completed the required training relevant to their roles. Staff told us they had completed their online training but that they did not have observation of their practice to ensure they were competent.
● Induction records did not evidence that new staff had received a full robust induction to the service and role. There were no systems for oversight and induction records were not completed or signed.
● There were no systems to ensure staff were competent in practical aspects of delivering care, such as the administration of medicines or moving and handling. There were no records of competency assessments and staff told us they had not had their practice observed. We had found similar shortfalls at our previous comprehensive inspection (published 21 October 2019)which had been remedied during that inspection.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider did not have robust systems to ensure people received the care and support they needed in a timely way. There were no clear systems to ensure staff understood the responsibilities relevant to their role, or systems to ensure action was followed up. We found examples where people appeared to have lost weight, their health appeared to be declining or they had been consistently refusing their medicines, but records did not demonstrate what action had been taken.
● Care records were not being accurately maintained and did not consistently evidence when people had seen health care professionals, why they had been seen or what advice had been given.
● Records for people who had recently tested positive for Covid-19 did not demonstrate that any additional monitoring was being competed to ensure any risk and deterioration in condition associated with the virus was quickly identified and appropriate treatment sought.
● On one day of inspection a person became unwell. We observed staff were kind and patient when supporting this person and sought medical advice and monitored them.

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 inspection (published 15 February 2021) we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our inspection (published 15 February 2021) we found the provider had failed to ensure they had oversight to ensure consistent good quality of the service. This was a breach of regulation 17 (1) (2) (a, b) of the Health and Social Care Act 2008 (regulated activities) regulation 2014.

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

● There was no home manager in post at the time of inspection. The nominated individual was on site daily but there was limited evidence to demonstrate they had oversight or management of staff within the home.
● There were no clear systems for staff communication and delegation of responsibilities. Where staff were completing specific roles, such as senior carer and deputy manager, it was not evident they had received the training and support they needed to undertake this role effectively. One staff member told us, "I feel like I'm constantly firefighting. I was meant to be shown how to do [certain tasks] but the staff member meant to show me has left."
● The provider had not ensured that recent checks of the quality of service and audits had been completed. This meant it was not possible to determine any learning or improvements to care.
● The manager's office was disorganised, and confidential records were not always being filed and securely stored. People were able to readily access the offices and access a variety of confidential records.

We were not assured that the provider recognised their responsibilities and was able to identify, address and sustain improvements within the service through good oversight and governance arrangements. This was a continued breach of regulation 17 (1) (2) (a, b, c, e) (3).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● We received mixed feedback about how the provider was meeting the duty of candour requirement to be open and honest with people. A number of sources suggested the provider would not always be forthright about the challenges being faced. We found the provider was not always proactive in seeking advice and

support when this was needed

● Staff told us they were not confident action would be taken when shortfalls were identified, or concerns raised. Staff told us they would often bring in resources to make up for any shortfalls, for example with cleaning equipment or toiletries.

● Some staff would try to provide meaningful and person-centred care and stimulation to people. However, there was no evidence that there was structured activities and stimulation for people prior to the recent outbreak of Covid-19. The risks associated with lack of stimulation had not been recognised by the provider, and appropriate steps to mitigate the risk had not been considered within any contingency management plan.

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

● The provider was not using systems to engage people. Surveys and other systems for feedback had not been recently completed. Records did not demonstrate that feedback from families, including complaints and concerns, were recorded and addressed. The nominated individual was able to feedback the actions they had taken in response to the one complaint that was recorded.

● Systems for communication with people and families were not being effectively used. There were no records of how families had been updated during the recent outbreak of covid-19. We requested contact details to obtain feedback from families, but these were not provided.

Working in partnership with others

● The provider was being well supported by the quality improvement team at the local authority. They supported the provider to develop an action plan to address the immediate concerns identified at inspection and through the local authorities' own checks within the home.

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 Systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preference was not being used effectively. Regulation 9 (1) (3).

The enforcement action we took:

We issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of people was not being consistently provided with the consent of appropriate people and in accordance of the Mental Capacity Act 2005. Regulation 11 (1) (3).

The enforcement action we took:

We issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not being assessed and mitigated as much as reasonably practicable. People's medicine was not being properly and safely used. The prevention, detection and control of the spread of infections was not icompleted effectively. Regulation 12 (1) (2) (a, b, g, h).

The enforcement action we took:

We issued a notice of proposal to cancel the provider's registration.

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 systems and processes were not established and operated effectively to prevent the risk of abuse or ensure effective investigation of allegation of abuse.

The enforcement action we took:

We issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always being met with the provision of a suitable healthy and balanced meals in line with people's assessed needs and preferences Regulation 14 (1).

The enforcement action we took:

We issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premise and equipment was not always suitable for the purposes it was being used and properly used and maintained. Regulation 15 (1) (c, d, e).

The enforcement action we took:

We issued a notice of proposal to cancel the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We were not assured that the provider is able to identify, address and sustain improvement within the service through sufficient oversight and suitable governance arrangements. Regulation 17 (1) (2) (a, b, c, d, e) (3).

The enforcement action we took:

We issued a notice of proposal to cancel the provider's registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Records did not demonstrate robust systems of recruitment were being completed prior to a new employee beginning to work at the home. Regulation 19 (2) (a)

The enforcement action we took:

We issued a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not sufficient numbers of suitable qualified, competent, skilled and experienced persons deployed to meet the needs of people living at the service. Staff were not consistently receiving appropriate support, training, professional development, supervision and appraisals as necessary to enable them to carry out their duties. Regulation 18 (1) (2) (a).

The enforcement action we took:

we issued a notice of proposal to cancel the provider's registration