Jasmine Healthcare Limited

Nightingale Nursing Home

Inspection report

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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
Nightingale Nursing Home is a nursing and residential care home providing personal and nursing care to people aged 65 and over. At the time of the inspection 28 people lived at the service. The service can support up to 49 people in one adapted building over two floors.

People's experience of using this service and what we found
Risks to people in relation to their personal care and health needs were not managed safely. People were at risk of developing pressure ulcers or existing wounds deteriorating. People at risk of falls did not always have information about their falls accurately recorded. Medicines were not well managed. People at risk of dehydration or malnutrition did not always have this managed safely. There were times when there was not enough staff to meet people's needs safely. Staff did not receive all the training necessary to keep people safe and provide care effectively.

Risks associated with the building environment were not well managed. For example, areas of the building were visibly damaged and therefore unable to effectively be cleaned to reduce the risk of infection. Equipment was not clean. The provider had not ensured the environment was suitable for people's needs.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

People were not always involved in planning or reviewing of their care, particularly where they were less able to communicate their needs. The provider had not taken steps to ensure that people were given information about their care and support in ways which were accessible for them. The provider did not ensure people's confidential personal information was stored securely.

The provider had not ensured systems and processes to assess risk and monitor quality were sufficient and effective in driving improvements. The provider's governance systems did not support staff to identify themes of concern and take appropriate action to maintain safe care in a consistent way. Audits of the quality of care were not effective at identifying issues. The provider did not consistently assess, monitor and mitigate the risks in relations to the health, safety and welfare of people.

People and their relatives generally felt the service was safe. It was difficult for some relatives to comment on aspects of the service's safety, due to restricted visiting during the coronavirus pandemic. Staff we spoke with demonstrated good knowledge of people's needs, but did not consistently get the support they needed to deliver care safely and effectively. Staff understood how to recognise and report concerns or abuse. Staff received training in safeguarding and felt confident to raise concerns. Relatives said all care staff were approachable, friendly and kind. We saw people using the service felt comfortable around staff, and interactions were unhurried, positive and friendly. The provider and staff team we spoke with were positive about being able to improve the service, and deliver high quality person centred care going forward.

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

Rating at last inspection
The last rating for the service under the previous provider was Requires Improvement, published on 12 February 2020. This service was rated requires improvement in December 2019 and March 2018. Prior to this, in August 2017, the service was rated Inadequate. In January 2017 and March 2016, the location was rated requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and poor quality of care. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
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 continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

Please see the action we have told the provider to take at the end of this report. We have served the provider with warning notices for breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A Section 29 warning notice tells a provider or registered manager that they are not complying with a condition of registration, requirement in the Act or a regulation, or any other legal requirement that we think is relevant.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Nightingale Nursing 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team comprised of two inspectors, a specialist advisor nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Nightingale Nursing Home 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 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 safety of the care provided. The registered manager was not available during our 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. We sought feedback from the local authority and the local clinical commissioning group about the service. We used the

information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with five people who used the service and observed how care and support was given generally. We spoke five care staff, including nurses, and four staff involved in activities, maintenance and catering. We spoke with the interim manager, the area manager, and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at a range of records including five people's care records and how medicines were managed for people. We also looked at staff training, and the provider's quality auditing system. During the inspection visit we asked the provider to give us additional evidence about how the service was managed, which they sent to us.

We 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.

After the inspection
We spoke with relatives after the inspection visit to get feedback from them about the quality of the service. We continued to seek clarification from the provider to validate evidence found and reviewed the evidence they sent us.

Inadequate

Is the service safe?

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 as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people in relation to their personal care and health needs were not managed safely.
- Two people were at high risk of developing pressure ulcers. One person had a pressure ulcer, and the other person had early signs of skin damage. Staff had not assessed the wound areas and neither person had a care plan in place to tell staff how to reduce the risk of further skin deterioration. A third person's care plan for repositioning to avoid skin breakdown did not contain sufficient detail. The plan did not tell staff how often to specifically reposition the person. This put people at risk of developing pressure ulcers or existing wounds deteriorating.
- People at risk of falls did not always have information about their falls accurately recorded. For example, one person had nine unwitnessed falls in April 2021. Care plans and risk assessments were not reviewed after each fall. The care plan did not state what risk reduction methods were in place to prevent the falls. Staff had not undertaken work themselves to try to identify the causes of falls. Although the person had been referred to the local falls team for assessment, there was a delay due to COVID-19. The person was at continued risk of falls and potential injury.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risks associated with the building environment were not well managed. We identified a number of fire safety risks which required immediate action to keep people safe. We liaised with the local fire service and provider to ensure the risks were mitigated.
- Rooms undergoing maintenance were not always locked to prevent people accessing them. We found a number of rooms containing tools and equipment. The door to access lift machinery was not locked and we saw a person trying to access this area. People were at risk from the hazards presented by tools and machinery which were not kept in secure areas.
- Ongoing issues reported by staff regarding the safety of the premises were not acted on in a timely way. For example, staff reported on three occasions that the cleaning cupboards would not lock, but no action was taken to make the storage area safe. This meant hazardous cleaning products were potentially accessible to people and visitors. The provider took immediate action to address the issues identified.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not well managed. Risks associated with the use of transdermal patches were not

managed well. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin. For one person, staff did not do daily checks to ensure the patch was in place. This put the person at risk of not receiving their medicine if, for example, the patch fell off or was accidentally removed.
● Another person was prescribed a transdermal patch which was recommended to be rotated around 14 different skin locations to reduce the risk of overdose. Staff and records confirmed the patch was only being applied to two sites on the person. This put the person at risk of an overdose and skin irritation.
● One person receiving oxygen therapy was not having their blood oxygen saturation monitored. This meant staff could not tell whether the prescribed therapy was effective and put the person's health at risk of deteriorating.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Each person's medicines record had key information about allergies and how people liked to be given their medicines.
● People received their "as and when" (PRN) medication when they needed it. There was guidance in place for people's PRN medicine which told staff when this medication was needed.
● Regular checks were in place to ensure people received their medication which helped staff to identify any missed medication doses.

Staffing and recruitment
● There were times when there was not enough staff to meet people's needs safely. Prior to our inspection, staffing levels had not been sufficient to meet people's needs. The provider had recognised this and has increased staffing levels.
● Staff confirmed that there had been periods of short-staffing and, until recently, absences were not being reported and gaps in shifts were not being covered. This has now been addressed by the provider.
● However, there were times during the day when it was a challenge for staff to be able to meet people's needs in a timely way. This included people's needs beyond functional personal care tasks, like being able to have time to talk with people and engage in activities with them.
● One person and a relative spoke about having to wait a considerable time for staff to come and support them with essential care needs, such as going to the toilet.
●There was pressure on staff to undertake essential record keeping/updating at the same time they were on shift to provide hands-on care. Staffing levels are being addressed by the provider to ensure all staff have sufficient time to carry out their work.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us the provider undertook pre-employment checks to help ensure prospective staff were suitable to care for people. Additional evidence from the provider confirmed this. The provider ensured staff were of good character and were fit to carry out their work.

Preventing and controlling infection
● Areas of the building were visibly damaged and therefore unable to effectively be cleaned to reduce the risk of infection. For example, damage to areas of skirting boards and a bathroom floor not sealed against skirting. Equipment was not clean. For example, some wheelchairs were dirty, and pressure cushions were stained. This put people at risk of preventable spread of infection.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was supporting staff to use PPE effectively and safely.
● 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 accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have signposted the provider to resources to develop their approach in relation to the correct wearing of PPE.

Learning lessons when things go wrong
● Accidents and incidents were reviewed and monitored to identify trends and to prevent reoccurrences. We saw documentation to support this, but it was not always clear that action was taken to minimise the risk of future accidents.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives generally felt the service was safe. It was difficult for some relatives to comment on aspects of the service's safety, due to restricted visiting during the coronavirus pandemic. Relatives told us they put a lot of faith in staff telling them honestly about their family members' well-being.
● Staff understood how to recognise and report concerns or abuse. Staff received training in safeguarding and felt confident to raise concerns.
● The registered manager and deputy manager reported any allegations or abuse to the local authority safeguarding team. The provider had policies on safeguarding people from the risk of abuse and whistleblowing, and staff knew how to follow these.

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● People at risk of dehydration or malnutrition did not always have this managed safely. Food and fluid charts did not document daily fluids goals for people, so staff could not quickly identify whether people were getting enough to drink. Records of meals did not state whether food was fortified or not, and staff were not able to confirm whether people who need a fortified diet got this. One person was prescribed food supplements. Records did not always document whether the person was getting this, and staff could not confirm if the person had the supplement as prescribed. This put people at risk of dehydration and malnutrition.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us the quality and variety of the food was good. People told us and records showed there was a varied menu, with options available for people with specific dietary requirements. Where people expressed views about wanting different options, or different times for their meals, their preferences were met.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider had not ensured staff understood the principles of the MCA, including how to support people to make their own decisions, and how to proceed if the person lacked capacity for a particular decision. Records of assessments of capacity did not document the views of people or relatives. There was no information about how choices had been presented to people in ways they could understand.

● Conditions associated with people's DoLS authorisations were not reviewed regularly to ensure they met

the principles of the MCA.

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives said staff gained permission before offering personal care. Throughout the inspection, we heard staff ask people when offering care and support and encouraging people to make their own decisions about their daily lives.
● The provider had assessed people to see if they were at risk of being deprived of their liberty and had made DoLS applications for a number of people.

Staff support: induction, training, skills and experience
● Staff we spoke with demonstrated good knowledge of people's needs, but said they did not always have enough time to read people's care plans.
● Staff described the induction they had, and said it was generally good. Induction included shadowing more experienced staff and being introduced to people before providing care and support. However, some staff felt their induction was very short, and they would have preferred more support before completing induction.
● Staff told us they did not always get regular supervision, where they could get feedback on their performance and discuss training needs. This meant they did not have the opportunity to know where they were doing well, and where they needed to improve.
● From an analysis of the provider's current training matrix, we identified there were still areas where staff had not received training as required by the provider. For example, 11 staff had not completed fire safety training, and 10 staff had not done any training on moving and handling. 13 staff had not completed training on safeguarding, and no care staff had undertaken training on tissue viability. This meant people were supported by staff who did not always have the skills to meet their needs.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives were positive about staff training and experience. People felt staff got the right training to meet their needs. A relative said they thought staff were well trained, and said their family member had fewer falls as a result of this.

Adapting service, design, decoration to meet people's needs
● The provider had not ensured the environment was suitable for people's needs.
● The service was not designed in a way which made it friendly and accessible to people with dementia. There was a lack of clear signs around the building to help people orientate themselves. For example, bedroom doors were a uniform colour and design, which meant people with dementia would have difficulty identifying their own room. Lack of consideration for the building design and decoration put people at risk of being disoriented. This had the potential to reduce people's independent skills. For example, where people were unable to locate the toilet due to lack of signs they could understand.
● The service was undergoing a substantial programme of refurbishment, and the provider had plans in place to ensure the building environment was more accessible for people living there.
● People were encouraged to make choices about decorating their personal space, and their bedrooms were personalised. There were also adaptations for people with mobility needs. For example, handrails in corridors and bathrooms.

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

● People had access to GP, dentist services and other healthcare professionals. Relatives said staff contacted them if their family member needed external healthcare services. Care records showed staff regularly contacted health professionals for advice if they were concerned about people's well-being.

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

● People's needs and choices were assessed in line with current legislation and guidance in a way that helped to prevent discrimination. Assessment of people's needs, including in relation to protected characteristics under the Equality Act were considered in people's care plans. Staff also had access to current information about a range of health conditions to ensure they were providing the right care.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● The provider did not ensure people's confidential personal information was stored securely. For example, both computer and paper-based care records were not secured when not in use. We also heard staff discussing confidential information about people's care in public areas where they could be heard by others. This meant information about people's health needs was not kept confidential, and compromised their right to privacy and dignity.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
● People were not always involved in reviews of their care, particularly where they were less able to communicate their needs. Staff said reviews of people's care plans were not always done with people, and records confirmed this. People were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats. The provider had not ensured people who required additional support with communication had their needs met.
● Relatives were disappointed with communication during the pandemic, and felt that getting information about visiting and updates on their family members was difficult. One relative said, "Communication during the pandemic has been poor, it's been very frustrating." Two relatives said they found out about visiting arrangements was by, "word of mouth."

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were familiar with people's verbal communication styles, and encouraged people to talk about how they wanted to be supported.

Ensuring people are well treated and supported; respecting equality and diversity
● Relatives said all care staff were approachable, friendly and kind. They said that, when they were able to speak with staff, they always got enough detail about how their family member was doing. One relative said, "Nightingale's strength is the quality of their carers."
● We saw people using the service felt comfortable around staff, and interactions were unhurried, positive and friendly. Care and support was offered by staff with warmth and good humour to everyone we saw.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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

● People were not consistently involved in planning and reviewing their care. Staff told us, and we saw people were supported to express their opinions about their daily lives, but this was not consistently evidenced in care records. For people who were less able to communicate verbally, there insufficient evidence how staff sought their views. Although staff we spoke with were knowledgeable about people's preferences and lifestyle choices, this information was not always recorded. There was a risk people's views and information about their lives were not available to support all staff in providing care.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recently employed an activities coordinator, but due to pressures on staffing, they had been asked to prioritise personal care for people. There was a range of activities offered within the service, but opportunities outside the service had been limited due to restrictions caused by coronavirus.

● Staff said activities had been limited during lockdown, but now that restrictions were being lifted, they were talking with people about future plans for doing things they enjoyed.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider had not taken steps to ensure that people were given information about their care and support in ways which were accessible for them.

We recommend the provider ensures that people are offered information about their care in ways that meet their communication needs.

Improving care quality in response to complaints or concerns

● People and relatives knew how to raise concerns or make a complaint. Information about this was available in the home. However, there was no evidence how people with limited or no verbal communication were supported to express their views in order to make a complaint. Although there were systems in place to investigate and respond to complaints in a timely manner, it was unclear if action was

taken as a result of the complaints. There was a risk the provider would miss opportunities to improve the quality of the service following complaints.

End of life care and support

● We looked at how end of life care was planned. People had advance care plans in place which included, where appropriate, records of their wishes about resuscitation. Staff received training in end of life care. People's care records did not consistently record how people had been consulted about end of life care. Staff confirmed it was not clear whether some people and relatives had not been asked, or if they had not wished to discuss it. We asked the manager to ensure they clearly recorded whether people had been asked about end of life care.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- The provider had not ensured systems and processes to assess risk and monitor quality were sufficient and effective in driving improvements. There was a lack of robust oversight of the quality of care. The governance systems did not support staff to identify themes of concern and take appropriate action to maintain safe care in a consistent way. For example, staff absences were not being reported and shifts not covered, leaving service users at risk due to lack of staff to support them. The provider had not been aware of this and was now taking action to address this.
- Audits of the quality of care were not effective at identifying issues. For example, two people's care plan audits identified a number of areas where work needed to be undertaken, but failed to identify who was responsible for addressing the outstanding actions. There was a risk that poor quality care would not be identified quickly and put service users at risk of harm.
- The provider did not consistently assess, monitor and mitigate the risks in relations to the health, safety and welfare of people. For example, checks on people's fluid intake did not pick up on missing information on daily fluid goals. This meant it was difficult for staff to identify who was at risk of dehydration.
- Quality checks in relation to the safety of the building had not identified or mitigated risks associated with fire safety systems or infection control.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was displaying their ratings from the previous inspection, both in the service and on their website, as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The provider had a registered manager in post. They had left the service just prior to our inspection, and the provider was in the process of recruiting a new manager.

Continuous learning and improving care; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Prior to our inspection, the provider had not always acted on feedback from staff. Some staff told us they did not feel confident their concerns or ideas for improving care would be acted on. We noted that the recent outbreak of coronavirus in the service, which was significant, impacted on both service users and the staff team. Feedback from staff about how they were supported and managed was mixed. Many staff felt unsupported, their concerns not listened to or acted on, and not having clear roles and responsibilities on

shift. This had an impact on both the quality of care and staff well-being.
● Learning from incidents was not always shared with staff to improve care. The provider was aware of this, and had begun to establish better systems to help them learn from accidents and incidents in future.
● The provider did not act on feedback received from health and social care professionals in a timely manner to reduce risks to people. Issues identified during a local authority and Clinical Commissioning Group visit on 20 May 2021 had not always been acted on. For example, the lack of wound assessments and care plans were identified on that visit. At the time of our inspection evidence we saw confirmed this had still not been addressed.

This was a breach of regulation 17 (Good governance) 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; 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
● Relatives did not feel that the service was well-led. One relative said they were not aware of any surveys or questionnaires for the provider seeking their views on the quality of care. Another relative said, "I am pleased the management is changing. I think they need someone in there who mixes with people." Relatives were also disappointed with the lack of communication from the service during the coronavirus lockdown.
● The management team and staff team understood their roles and were open and honest during our inspection.
● The provider was aware of the requirement to notify the CQC of certain incidents, and our records showed that these notifications were sent in as required.
●The provider and staff team we spoke with were positive about being able to improve the service, and deliver high quality person centred care going forward. The provider acknowledged there had been failures in the past, and that improvements were still required and ongoing, but were positive about the progress they felt was being made.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always involved in planning or reviewing of their care, particularly where they were less able to communicate their needs. The provider had not taken steps to ensure that people were given information about their care and support in ways which were accessible for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured staff understood the principles of the MCA, including how to support people to make their own decisions, and how to proceed if the person lacked capacity for a particular decision. Records of assessments of capacity did not document the views of people or relatives. There was no information about how choices had been presented to people in ways they could understand. Conditions associated with people's DoLS authorisations were not reviewed regularly to ensure they met the principles of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Areas of the building were visibly damaged and therefore unable to effectively be cleaned to reduce the risk of infection. Equipment was not

clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were times when there was not enough staff to meet people's needs safely. Staff did not receive the training and support they needed to care for people safely and effectively.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to people in relation to their personal care and health needs were not managed safely. Medicines were not well managed. People at risk of dehydration or malnutrition did not always have this managed safely.

The enforcement action we took:

We have served the provider with a warning notice for breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	The provider had not ensured systems and processes to assess risk and monitor quality were sufficient and effective in driving improvements. There was a lack of robust oversight of the quality of care. Audits of the quality of care were not effective at identifying issues. The provider did not act on feedback received from staff and health and social care professionals in a timely manner to reduce risks to people. The provider did not ensure people's confidential personal information was stored securely.

The enforcement action we took:

We have served the provider with a warning notice for breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.