Mrs R Ghai

Marlyn House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
Marlyn House is a care home providing personal care for up to 18 older people. People have access to their own bedroom along with communal spaces including lounges and gardens. At the time of our inspection there were 10 people living at the home, some of whom were living with dementia.

People's experience of using this service and what we found
People were not receiving safe care as their needs were not always understood and risks were not managed in a safe way. Care plans and risk assessments that had been introduced did not have the detailed information in to keep people safe. Plans were not reviewed and updated following incidents. People were not always protected from harm as incidents were not always reported to ensure appropriate action was taken. There was a lack of understanding from staff as to why incidents needed to be reported and the importance of safeguarding people. Improvements were needed to ensure all medicines were administered as prescribed. There were limited activities taking place which meant people were sometimes sleeping.

People were not always supported in a dignified way. The language used in the home was not always dignified. People's communication needs were not fully understood and therefore people did not always receive the support they needed.

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.

The provider continued to fail to ensure lessons were learned when things went wrong. The provider was unable to sustain improvements made and demonstrate they were able to support people safely. The systems in place were not effective in identifying areas of improvement.

Peoples needs were assessed but evidence was needed to show people and families were involved with this. Staff had received an induction and training. There was a complaints policy in place, and this was followed when needed. People had plans in place that considered their end of life care.

People enjoyed the food, and their dietary needs were assessed and considered. Referrals were made to health professionals for support when needed.

There were enough suitably recruited staff available to support people and people were happy with the staff team that supported them. People felt their independence and privacy was promoted.

Improvements had been made to the home environment and infection control procedures were in place and followed.

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

Rating at last inspection and update
The last rating for this service was requires improvement (Published 27 October 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marlyn House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the dignity and respect, how people are safeguarded, the care and support they received in relation to risk management, capacity and consent and the systems in place to ensure the home is effectively governed.

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.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
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**

Marlyn 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 was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector 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
Marlyn House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under 1 contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection, including notifications

the provider had sent to us and information received from the public. We also gathered feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service. We also spoke with the provider, the registered manager and 3 care staff, 1 of which was a senior. We looked at the care records for 9 people and medicine records for 10 people. We checked the care people received matched the information in their records. We looked at records relating to the management of the service, including audits and recruitment checks carried out within service.

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 we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

The provider had failed to make the necessary improvements to ensure people receive safe care and treatment, whilst living at Marlyn House. The provider has now been in continued breach of regulation 12 since our inspection in November 2019.

Assessing risk, safety monitoring and management

- Risks to people were not managed in a safe way. For example, 1 person had a health condition that needed monitoring. There was no detailed guidance in place, to show how this was monitored or what action to take if they were displaying symptoms that may mean they were unwell. The person was experiencing symptoms and although the provider had sought advice from medical professionals there were no plans in place identifying how this should be managed. Staff were supporting this person in an inconsistent way, and this had resulted in paramedics being called to this person on 3 occasions in a 7-day period. This placed this person at an increased risk of harm.
- Positive behaviour support plans (PBSP) for people had been introduced for people who were displaying periods of emotional distress. However, they had not considered all incidents that had occurred. For example, 1 person had a PBSP in place that related to them becoming 'agitated' during an activity. We saw an incident form had been completed where they had been physically aggressive towards a staff member. The care plan had not been updated to reflect this and there was no guidance in place to advise staff what to do should this reoccur. The registered manager confirmed there was no plan in place and was unable to demonstrate they understood why this would be needed. We found the same concern for 2 other people. This placed people and others at continued risk of harm.
- Care plans and risk assessments were not always updated in response to incidents that occurred at the service. This placed people at risk of not receiving the support they needed.
- The provider did not follow their own procedure to ensure people were safe. Staff told us and the registered manager confirmed there should be a staff member present in the lounge at all times. We saw for periods throughout our inspection there was not always a staff member in the lounge. Although no one came to any harm during our inspection this placed people at an increased risk of harm.

Learning lessons when things go wrong

● Lessons were not being learnt when things went wrong within the home as the provider remained in breach of regulations and the rating of the home had deteriorated.
● When incidents occurred within the home these were not always recorded on incident forms, this meant action was not always taken. For example, we saw numerous incidents documented on the handover records, including periods of emotional distress, a medicine error and that someone potentially had been smoking within the home. We discussed this with the provider and registered manager who were unaware these had occurred. No action had been taken to reduce the risk of these reoccurring and some of these incidents continued to occur.
● There was a lesson learnt log in place however it was unclear how this was being used, the registered manager or provider could not explain this to us. Despite some improvements at our last inspection, we again found incidents were not being identified or reviewed to reduce the risk of reoccurrence. Therefore, this information was not used to ensure lessons were learnt after incidents occurred to ensure people were safe.

Using medicines safely
● Medicines were not always administered as prescribed. One person was prescribed a patch to be administered to their skin each week to manage their pain. We saw documented on a handover sheet this patch had been found on the floor. There was no incident form in place for this and no documentation in place identifying the action taken.
● After our inspection the registered manager confirmed to us that following the incident no action had been taken and the person had waited over 36 hours before the patch was readministered. They told us they had also identified a second incident that had occurred. This meant this person had been placed at an increased risk of unnecessary pain as they had not received their medicines as prescribed.

Incidents were not always documented to ensure action was taken. Risk assessments and care plans were not always in place or reviewed to include incidents that had occurred. People did not always received medicines as prescribed. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider had been unable to sustain the improvements made at the last inspection and safeguarding concerns were not always identified or reported as needed. The safeguarding procedures in place were not always followed.
● There had been an incident within the home where a person had not received pain relief. This incident had not been investigated and the provider and registered manager were not aware of this until we identified it. After our inspection we had to ask them to raise this with the safeguarding team as they had not done so. The correspondence we received from the registered manager demonstrated they did not understand the safeguarding process in relation to this incident.
● When incidents had been recorded on incident forms these were investigated and reported to the safeguarding team. However, we could not be assured all incidents had been reported as needed. We found when incidents had been documented in other places such as handover sheets, the registered manager was not aware and subsequently no action had been taken. This placed people at an increased risk of abuse.
● Staff told us they had received training and were able to explain safeguarding to us. However, we were not assured they understood the importance of this as they were not recording and reporting incidents correctly to ensure appropriate action was taken.

People were not protected from potential abuse as incidents were not always documented and reported so that action could be taken. This was a breach of regulation 13 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Staff and recruitment
● There were enough staff available to support people. One person said, "There are enough staff on duty, I think".
● Staff gave us mixed reviews on staffing level in the home, but they did tell us no one had come to harm because of this.
● There was a dependency tool in place based on people's needs, there were the correct amount of staff available based on this tool.
● We saw staff had received the relevant pre-employment checks before they could start working in the home.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● There were no restrictions placed on visiting and visitors could access the home freely.

Using medicines safely
● Other people were happy with how their medicines were administered. One person said, "The staff give me my medication, I know what I am taking, they wear gloves and wash their hands after I have had them, they stand over me to make sure I have taken them."
● When people were prescribed 'as required' medicines there were protocols in place to ensure staff had the information to administer these medicines when people needed them.

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 last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At our last inspection the provider had failed to ensure the principles of MCA were followed. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

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).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met. We checked whether the service was working within the principles of the MCA.

- The principles of the MCA were not followed or understood. Not all people had a DoLS in place as needed. For example, 1 person had restrictions placed upon them and they were not free to leave the home. There were capacity assessments and best interests' decisions in place for this that identified they lacked the capacity to make these decisions. The registered manager told us they had not applied for a DoLS for this person as in 2020 they had been assessed as having capacity. The registered manager had not recognised that someone's capacity may change. This meant this person was being restricted without the legal powers to do so and there was a lack of understanding around this process.
- Another person's food intake was being restricted; we saw this was documented in staff meeting minutes. There were no care plans or risk assessments in place identifying this. We discussed this with the registered manager who told us they had introduced this as they felt this was impacting on their health. They confirmed no medical advice had been sought. There were no mental capacity or best interests decisions in place for this restriction and this had not been considered as part of this persons DoLS.

● The provider had not considered that taking someone's blood sugars when they were unable to consent would need to be assessed and completed in their best interests.
● Some mental capacity assessments were in place when needed. However, it was unclear how decisions had been made. For example, it was documented that people did not have capacity due to their health condition such as Parkinson's Disease. The provider had failed to understand and identify that a health condition alone such as Parkinson's Disease did not mean they did not have capacity.
● There continued to be inconsistences recorded within people's care files. For example, 1 person had a mental capacity assessment and best interest decision in place that deemed they lacked capacity to make decisions around their medicines. In this person care plan for medicines, it stated they could consent to their medicines being administered. These inconsistences placed people at risk of not being supported correctly.
● Although the registered manager told us they had completed training since our last inspection the action they took and through discussions it was still clear they lacked understanding in this area.

The provider had failed to support people in line with the principles of MCA. This placed people at an increased risk of harm. This is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff did not always have the skills or knowledge to support people. Staff told us and records confirmed staff had received training. However, we could not be assured this was effective in ensuring people were safe and their needs met. For example, staff had received training in safeguarding however they had failed to ensure incidents were documented and reported to ensure people were protected from abuse.
● The staffs competency was checked in some areas such as medicines management. However, we could not be assured that this competency process was effective as staff who had been deemed competent in medicines administration had on two occasions left a person without their prescribed pain relief.
● Staff were unable to demonstrate they had the skills or knowledge to support people with their communication needs, including people living with dementia. We have reported on this under the responsive key question in this report.
● Staff told us they had received an induction when starting in the home which included training and shadowing more experienced staff so that people could get to know them.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● It was unclear if professionals' advice was always followed. For example, the provider and registered manager were unable to confirm the action they had been told to take with regards to a person who had a health condition that needed monitoring. We asked for this action to be confirmed with us following our inspection. However, we did not receive this information as requested.
● People were referred to health professionals for support. We saw referrals had been made to speech and Language Therapists (SALT), GP's and district nurses.
● People's oral health care needs were considered and there were plans in place identifying the levels of support they needed.

Adapting service, design, decoration to meet people's needs
● At our last inspection improvements were needed to ensure the home was dementia friendly. For example, there were no signs or pictorial guidance to support people to orientate themselves within the home. At this inspection we found the same concerns and the registered manager and provider told us no action had been taken.

● The areas of the home that were tired and stained had been repaired at this inspection. The provider told us the plans they had in place to consider other areas of the home in the future.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● At our last comprehensive inspection, we found the service did not evidence they used assessments to support person centred care. At this inspection we found assessments were in place for people. These assessments had considered people's characteristics and their cultural and religious needs.

Supporting people to eat and drink enough to maintain a balanced diet
● The mealtime atmosphere was relaxed, and people enjoyed the food. One person said, "The meals are good, there are always 2 choices, but I have a sweet tooth and prefer puddings".
● People were offered a verbal choice of meals and if they did not like or want something on the menu, they could have what they requested. One person said, "The food is alright, I have a lot of dislikes and they listen."

● When needed, people received support to eat and drink.
● When concerns had been identified with people's eating and drinking, people had received support from the speech and language team (SALT). Care plans and risk assessments were in place that reflected people's dietary needs and we saw people were supported in line with these.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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, Ensuring people are well treated and supported; respecting equality and diversity

- People were not treated in a dignified or caring way as their individual needs were not always understood. One person had a cognitive impairment, there was a lack of understanding around the support this person may need. We saw frequently recorded that during the night this person would press their call bell for 'no apparent' reason. Staff responded by silencing the call bell and no further action was taken to resolve this. We discussed these concerns with the provider who was unable to demonstrate they understood the needs of this person.
- Furthermore, the language used in the home was not always dignified. There was a care plan in place for the person who frequently pressed the call bell. The care plan stated the person 'liked to play up staff'. When we discussed this person with the provider, they referred to them using a derogatory comment.

People were not always supported in a dignified way as their needs were not always understood. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were happy with the staff that supported them. One person said, "The staff are kind, they chat with me, I like them all." Another person said, "The girls are nice, they come and chat with me when I am in my room, they listen to me, and I feel like I am listened to."
- Staff were able to tell us information about people and what was important to them.
- The provider had recorded compliments received from people and their relatives.
- People's privacy was encouraged. We observed this during our inspection. One person said, "The staff are always polite, they respect my privacy in my room, knocking first, I feel they treat me with respect."
- People were supported to remain independent. Care plans reflected the levels of support people needed with tasks.

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

- In people's care plans there was a monthly review that was taking place, this was completed by staff. When people were able to verbally communicate, they told us they were involved with this. One person told us, "I haven't seen my care plan, but I tell them what I want, how I want it and what I don't want."
- It remained unclear how other people and their families were involved with their care and decision making. The registered manager told us they had verbally spoken to families when reviewing people's care however there remained no evidence to support this.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carer's, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were not fully understood within the home. When people had dementia, for example, there were no plans outlining the support they may need. The registered manager told us although people could verbally communicate, pictures were also available to support people to make choices for example at mealtimes. Care plans were not reflective of this, and we saw these pictures were not used when people were asked what they would like to eat. This meant people may not have been effectively able to make or communicate their choices.
- Other people had communication plans in place that identified if they wore glasses or if they were hard of hearing.
- A pictorial activity board was in place in the lounge, however the activities that were on the board for the day of inspection were not completed. We discussed this with the registered manager however, they had failed to understand how confusing this may have been for someone living with dementia.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.

- People did not always have control over their lives as all people were not always encouraged to express opinions.
- Care plans in place were not always reflective of people's current needs as reported on under the safe key question in this report.
- When care plans were in place, they had been updated to include people's preferences, likes and dislikes.

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

- There was a programme of social activities. However, this was not always followed as there were no dedicated activities staff working at the service. On the day of our inspection, the activities board showed that baking and knitting were the activities for the day. However, these activities were not facilitated as planned. Instead, people were watching the TV or listening to the radio, some people also visited the hairdresser who was on site. Some people were engaged by this, whereas others were sleeping.
- People and staff told us that some activities were facilitated when staff had the time to do this. One person said, "I like to join in the bingo, I always get up for that."

● People were supported to have regular contact with their family and friends.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place. When complaints had been made, the provider had responded to these in line with their policy.

● People knew and felt able to complain. One person said, "I haven't had to complain, but I would complain the registered manager or the owner."

End of life care and support

● Where people were coming to the end of their life, plans had been put into place detailing about where and how the person wished to be supported.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question 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

At our last inspection the provider had failed to operate good governance systems to assess, monitor and improve the quality and safety of the services provided. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The provider had failed to operate good governance systems to assess, monitor and improve the quality and safety of the services provided. The provider has now been in continued breach of regulation 17 since our inspection in March 2017.

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

- The service has a history of non-compliance which dates back to 2016. This is the 8th time we have inspected this service and the highest rating achieved is requires improvement. This is the 4th time well-led has been rated as inadequate.
- The provider is unable to demonstrate they are able to sustain any improvements that are made. For example, after our inspection in May 2022 we identified a breach of regulation 13. At our inspection in October 2022 improvements had been made and this breach was removed. After this inspection the provider in now again in breach of regulation 13.
- The provider sends us a monthly action plan as a result of enforcement activity from a previous inspection. We reviewed this action plan as part of this inspection. This action plan is not effective as it shows areas relating to safeguarding and incident and accidents are now completed. During our inspection we found concerns in both these areas.
- There are various audits completed in the home, including medicines management, infection control procedures and people's care (weights, fluid intake). These audits were not effective as they were not identifying concerns. For example, the medicines audit had not identified the 2 occasions when the person's medicine patch was not replaced in a timely manner.
- Audits within the home were not effective in ensuring action was taken following an incident. Only incidents that were recorded on incident forms were reviewed to ensure action were taken. There was no system to check other records to identify other incidents. We found several incidents recorded in handover records where no action had been taken.
- The systems in place to ensure staff were trained or competent to administer medicines to people were

inadequate, as staff had not taken any action to resolve the concerns we identified.
● The systems the provider had in place to keep people safe were not effective. For example, we saw 3 people in the home required to be weighed weekly due to weight loss. We saw for 1 week this was not completed; no audit had identified this, and the provider or registered manager was not aware. After discussion it was identified this was not completed as the staff member responsible had been off sick.
● The system in place to ensure a staff member was present in the lounge to keep people safe was not effective, as we saw periods where there were no staff present.

There remained insufficient oversight of the service and the measures in place were not always effective in identifying areas of improvement. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We had been notified about events that had happened within the service when needed.
● Staff understood their roles and responsibilities and there were lines of delegation since the introduction of the new registered manager.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
● The systems in place had not ensured people received care and support which was person-centred. The provider, registered manager and staff did not always fully understand the needs of people. Where people had not had their needs met or understood this had not been identified or actioned as part of the quality assurance processes. This placed people at an increased risk of not receiving person-centred care.
● The provider was in breach of multiple regulations which led to people being at risk of not receiving safe, effective and person-centred care.
● Overall people told us they felt happy living in the home. One person told us, "Overall I would describe the home as friendly."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People who could not verbally communicate were not always involved in developing and feeding back about their care. When people were able to verbally communicate and understand, there was some evidence to show how they had been involved with their care.
● Feedback had been sought from people and relatives; satisfaction surveys were completed in January 2023, however no action had been taken to collate this information or use this to make improvements within the home. The registered manager told us they displayed this on a 'you said we did board', however the information recorded on there did not reflect the information in the surveys.
● The registered manager told us they planned to start a residents meeting however this had not yet commenced.
● Staff attended supervisions and team meetings so that they could share their views. They told us they felt comfortable to do so. Staff felt supported and listened to by the registered manager and provider.

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
● When incidents or areas of concern had been reported in the service, the registered manager and provider were more open and transparent and had shared these with the relevant people. However, as the registered manager and provider were not always aware of all incidents within the home we could not be assured the duty of candour requirements were consistently met.

Working in partnership with others

- The service worked with other agencies to ensure people received the care they needed.
- There was involvement from health professionals in the home and the registered was open to working with other professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always supported in a dignified way as their needs were not always understood.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of MCA were not followed or understood.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Incidents were not always documented to ensure action was taken. Risk assessments and care plans were not always in place or reviewed to include incidents that had occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from potential abuse as incidents were not always documented so that action could be taken.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

There remained insufficient oversight of the service and the measures in place were not always effective in identifying areas of improvement.