Caritate Limited

Caritate Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Caritate Nursing home is a residential care home providing personal and nursing care to up to 24 people. The service provides support to people of all ages with a range of health needs, physical disabilities and people living with dementia. At the time of our inspection there were 22 people using the service.

People's experience of using this service and what we found
Medicine records were not always accurate. A recommendation, which was made in our last report, had not been actioned and the same concerns remained. Some people did not receive their medicines as prescribed. A recent audit had not identified the issues found at this inspection.

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; there was a lack of policies and systems in the service to support best practice. Some people were being restricted without an appropriate authorisation. The registered manager did not have a thorough understanding of the legislation laid out in the Mental Capacity Act 2005.

Staff had not been provided with regular supervision and appraisal. Training updates had not always been provided in a timely manner. The registered manager did not have access to some specific training details of the staff as they were held on a different system on another member of staff's computer.

Nurses professional registration details with the Nursing and Midwifery Council (MNC), required for them to practice, were not routinely monitored. Risks were not always identified or safely managed. Staff did not always have the necessary guidance in care plans to help them support people to reduce the risk of avoidable harm.

Everyone in the service had a care plan. However, it was not always clear from people's care plans if they required specific care or monitoring. Monitoring charts were not formally checked regularly, so any gaps or concerns would not be identified in a timely manner. Some guidance in care plans was not always being followed by care staff. Staff were not always aware of people's specific care needs.

People's communication needs were identified. However, care plans did not contain adequate specific guidance for staff around supporting people who did not have the ability to communicate verbally.

Care plans did not always contain direction for staff regarding the provision of oral care for people who were not having any food or drink orally. However, we were shown that staff were recording when they carried out mouth care on room-based records.

Infection control processes and procedures were not always robust. Prior to this inspection the registered manager had agreed to all staff dispensing with the wearing of face masks, even when working closely with

people such as during personal care. This was not in line with the current guidance. The registered manager took advice and re-instated the wearing of masks immediately upon the inspector's arrival.

There was a lack of robust governance of the service provided. The registered manager had delegated most audits and processes to other staff but did not have oversight of their actions or the information gathered.

There was a designated activities staff member to assist people. However, some people reported being bored and we saw no activities taking place during this inspection. Interactions between staff and people was task based.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

The registered manager was not aware of the guidance and people were not being supported in line with the underpinning principles of Right support, right care, right culture. Although other agencies had provided additional support and guidance, specifically for these people, this had not been implemented or used to improve people's experiences. They were not given opportunities to access their local community or take part in meaningful pastimes that mattered to them. Staff did not have the necessary skills to effectively engage with them.

Some people living at the service were cared for in bed due to their health care needs. These people had been assessed as requiring pressure relieving mattresses to help ensure they did not develop pressure damage to their skin. These mattresses were set correctly for the person using them.

People told us they were happy with the care they received, and people said they felt safe living there. Staff knew how to keep people safe from harm.

People looked happy and comfortable with staff supporting them. Staff were caring. People were supported by staff who knew them well. Many staff had worked at the service for a long time.

Staff were recruited safely in sufficient numbers to ensure people's needs were met.

People and their families were provided with information about how to make a complaint and details of the complaint's procedure were displayed at the service.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was good (Published 28 November 2017). At this inspection the rating has deteriorated to requires improvement

Why we inspected
We received information of concern in relation to the governance of the service, staff support and

restrictions in place for some people that may not have been appropriately authorised. We carried out a focused inspection covering Safe, Effective and Well led.

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 good to requires improvement. This is based on the findings at this inspection.

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

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 take further action if needed.

We have found breaches in relation to medicines management, consent, staff support, and governance of the service.

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

Follow up
We will request an action plan 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always 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.

Caritate Nursing Home

Detailed findings

Background to this 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.

Inspection team
The inspection was carried out by two inspectors 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
Caritate 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. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we held about the service and the provider which included any statutory notifications sent to the CQC. A notification is information about important events which the service is required to send us by law. We used the information the provider sent us in the provider information return. 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 of this information to plan our inspection.

During the inspection
We reviewed 6 people's care plans and risk assessments. We reviewed staff training and supervision. We also reviewed other records relating to the management of the service. We spoke with 5 people and 8 staff including the registered manager, the team leader and the administrator. We spoke with a visiting relative. We spoke on the phone with 2 relatives of people who lived at Caritate.

Requires Improvement

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 good. At this inspection we have rated this key question requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
At our last inspection we made a recommendation that systems were put in place to ensure that accurate records in relation to medicine administration and management were maintained.

At this inspection we found some concerns remained.

- One person did not have one of their prescribed medicines available to them. They had missed seven days of this medicine dose, according to the records. This concern had not been identified by staff, neither had any action been taken to obtain this medicine. We advised the registered manager to contact the GP and the safeguarding unit regarding this concern.
- One person's epilepsy medicine was recorded as 'not available' to be given as prescribed. Staff needed to arrange for this to be dispensed urgently and collected in person, to be able to administer this required medicine late.
- One person's care plan highlighted that they were allergic to fish. However, this was not known to the kitchen staff, and the team leader told us, "They have had fish to eat regularly, they enjoy it." This person had an immune deficiency but there was no specific risk assessment to guide staff on how to manage this risk.
- Monitoring systems, designed to highlight any increase in risks to people's well-being, were not robust. One person had a low recorded weight and their care plan stated their weight should be checked weekly. We were told they were having their food and drink recorded, however, this was not stated in the care plan. This person did not have their weight checked weekly, with gaps on the weeks beginning 26 September, 25 October and 7 November 2022. This meant the risk of this person losing further weight would not be identified in a timely manner. Their food and drink monitoring record also had many gaps where no records were made. For example, no drinks were recorded at all on 6 November 2022 or 8 November 2022. The registered manager addressed this at the inspection.
- Some people living at the service had been assessed as being at risk from having seizures. CCTV monitoring was in place when these people were in their rooms. However, there was no evidence of review of the risk from seizures in their care plans. These people spent most of their day in the communal areas with no close monitoring in place. One person's care plan stated, "(Person's name) needs to be monitored regularly day and night to maintain their safety." Inspectors observed this person throughout the morning of the inspection and there were many periods of time when there were no staff in sight. This meant staff were not following the guidance in the care plan.

The failure of the provider to ensure care and treatment was provided in a safe way is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2009 (Regulated Activities) 2014

● MAR's contained gaps where staff had not always signed to show they had administered prescribed medicines. This meant the MAR was not an accurate and complete record.
●There were not always protocols in place to guide staff on when to give medicines that were prescribed "as required" medicines. This meant staff might not have made consistent decisions about when to give these medicines.
● One person was administering their own medicines. There was also no assessment in relation to the safe storage of these medicines.
● Stock management was not effective. Staff were directed to count tables following each administration. This was not always completed. The tallies of some medicines were inaccurate.
●There was not an effective audit process in place for the registered manager to effectively and regularly monitor all aspects of the recording and management of medicines. This meant any errors were not identified in a timely manner.
● Not all staff had received training in medicines administration. Only three of the seven nurses working at the service had been recorded as having completed medicines administration training. This meant the provider could not be assured that staff administering medicines were competent to do so. NICE SC1 states all care homes should have annual reviews of skills, knowledge and competencies relating to medicines.

The failure of the provider to assess, monitor and mitigate risks relating to the health, safety and welfare of the service users is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2009 (Regulated Activities) 2014

Assessing risk, safety monitoring and management
● Risks associated with people's care needs were identified and recorded. However, there were not always the required risk assessments in place to guide and direct staff on how to reduce known risks. For example, two people we reviewed were having their food and drink monitored, due to concerns with their intake, but there was no indication of this in their care plans.
● One person had been taken to hospital due to an acute event, two days before this inspection. Advice was provided to the service to change the person's diet and obtain a Speech and Language Assessment (SALT). The last time this person's care plan had been reviewed was September 2022. There had been no review of this person's care plan or risk assessments in light of the acute event. This was addressed by the registered manager during the inspection.
● Accidents and incidents were recorded by staff and passed to the registered manager. These were not audited. They were filed in the person's care plan. This meant there was no robust overview held by the manager of any patterns or trends and the opportunity to reduce reoccurrence may have been missed.

The failure of the provider to assess, monitor and mitigate risks relating to the health, safety and welfare of the service users is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2009 (Regulated Activities) 2014

Preventing and controlling infection
● When the inspectors arrived at the service staff were not wearing face masks, even when working closely with people such as when carrying out personal care. This was not in accordance with current guidance. The registered manager had made the decision for staff to stop wearing masks without any risk assessment in place. This meant there was a potential risk of COVID-19 infection being spread throughout the service. The registered manager was advised, and the wearing of face masks was reinstated for staff. Following the

inspection visit, the registered manager sent CQC a COVID-19 risk assessment which contained information which was not in line with current guidance. We referred them to the public health team for support.
● We were not 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 not assured that the provider was using PPE effectively and safely. However, this was reinstated at the time of this inspection.

● We were assured that the provider was accessing testing for people using the service and staff. Staff and people were being tested if they presented with symptoms.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were somewhat 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.

The registered manager had been asking all visitors to make appointments and had been limiting visitor numbers at specific times throughout the day. The registered manager was advised that there was no longer any government guidance supporting this restriction on visiting. The registered manager assured us that the appointment system would be stopped, and they would formally inform all families and friends that they could visit whenever they wished.

Staffing and recruitment
● There were sufficient staff employed to meet people's needs. People and relatives confirmed this.
● Staff said they covered any sickness or annual leave and worked additional hours were possible, so people had staff they knew and trusted. However, the service had used agency staff to cover vacant posts, to ensure there were enough staff available.
● There were appropriate recruitment processes and procedures in place for new staff.

Systems and processes to safeguard people from the risk of abuse
● The registered manager was fully aware of their responsibilities to raise safeguarding concerns with the local authority to protect people. However, they had failed to notify CQC appropriately of safeguarding concerns. This is covered further in the well-led section of this report.
● The service had systems in place to protect people from abuse.
● People told us they felt safe. Relatives were confident their loved ones were safe.
● Staff had received training in safeguarding and whistleblowing. Staff understood to report any concerns they had to the registered manager.

Learning lessons when things go wrong
● There was a lack of oversight and governance of the service which meant opportunities to improve the service may have been missed.
● The registered manager told us they would be aware of any complaints or concerns raised. No complaints

were in process at this time.

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 our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

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

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. 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.

- Prior to this inspection a Direct Monitoring Assessment (DMA) was carried out. A DMA is a planned video call between a CQC inspector and the registered manager. This identified that some people were being closely monitored in their rooms by CCTV. The registered manager was unable to provide the required documentation to show that the legislation had been complied with prior to CCTV being installed.
- At this inspection the registered manager believed that one of these people, had CCTV installed in their room many years ago, and had all the necessary permissions and documentation completed and a DOLS authorisation had been put in place to cover this in line with legislation. This information was not held in their care plan. We contacted the local authority DOLS team for clarity on this matter. There was no mention of the use of CCTV on the original DOLS authorisation, which had expired in 2019. The registered manager had re-applied in 2019 for a new authorisation, but had not included the CCTV monitoring restriction in place, and so this was waiting to be authorised as a low priority as the DOLS team were not aware of the high level of restriction in place.
- Only one person, of the five, had the necessary documentation to demonstrate how the decision had been made, prior to the installation of CCTV in their rooms. The DOLS team have now been in touch with the registered manager to plan an assessment of this situation as a matter of urgency.
- It was not clear in people's care plans if they had a Lasting Power of Attorney (LPA) in place before relatives and friends were asked to sign consent forms on another person's behalf. We found consents had

been signed by people who did not have the legal authority to do this.
● Two people had been placed in the same bedroom without the correct consideration being made regarding consent, capacity assessments and best interests' meetings. Families were not involved in this decision and had raised their concerns to the CQC about it.
● One person's care plan stated, "(Person's name) cannot make any form of decision, verbally or otherwise." This was an inaccurate statement which demonstrated a lack of knowledge and understanding of the person's abilities and the MCA.

The failure of the provider to act in accordance with the requirements of the Mental Capacity Act 2005 is a breach of Regulation 11 (Consent) of the Health and Social Care Act 2009 (Regulated Activities) 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were not supported in line with their preferences. Care plans did not always provide sufficient guidance and direction for staff to meet people's specific needs. Whilst we saw that some staff were skilled in supporting specific people, not all staff knew how to support them well. We observed staff approach a person and move them without speaking to them. Staff showed a lack of understanding of some people's needs. This meant people did not always receive person centred care.
● Caritate had been specifically commissioned to provide support from one dedicated member of staff, known as one to one support, each week, for some people living at the service. This was not always provided in a person-centred manner. For example, this specific support was only provided when sufficient numbers of staff were available and not every day at regular intervals as had been assessed. One care plan stated, "(Person's name) will benefit from a routine of structured short periods of activity in their daily routine. An activity planner may help staff establish a routine of daily activities." This was not being done. Records stated that the person did get tired when a whole day of one to one support had been provided. However, this continued to be provided when staff were available. There were days when no one to one support was provided. One staff member commented, "They probably get bored, I would not want to sit there with nothing to do."
● There was no activity provided for people on the day of this inspection. People told us they were bored. Comments included, "I'm bored, the days are the same. I don't feel I can join in the activities in the home, my hands won't allow me. I would like to go to the pub for a pint." We observed very little interaction between people and staff unless it was in relation to a task such as support with food or drink or support to use the bathroom.
● We received confirmation from the learning disability team on 15 November 2022 that comprehensive advice, guidance and direction had been provided for the service over many years. There was clear guidance provided on how to interact and provide stimulation for people with a learning disability. This guidance was not being followed.
● There was no evidence of the person, or their relatives, having been involved in the creation or review of care plans. Care plans focused on care needs and there was little record of how the person liked to spend their time. Whilst activities were provided, they were not always person-centred. One person's care plan stated, "Low in mood maybe a little bored." One relative told us, "I have not met with the manager or anyone formally and no one has asked me about (Person's name) needs or preferences. I was just asked to sign some forms."
● People's care plans included their communication needs. Some people were not able to fully communicate verbally. There was not enough information in the care plan for staff who needed to anticipate people's needs if they could not use words to communicate. Care plans did not always provide sufficiently detailed guidance for staff on how the person communicated and how they liked to receive information.
● We observed staff who did not know how to effectively communicate with some people. Staff we spoke

with were not all clear on any consistent approaches that were effective or how each person communicated.
● We were told one person was blind. This person's care plan did not make this clear or provide adequate guidance and direction for staff regarding their lack of sight, to ensure consistent approaches were always used.

The failure of the provider to ensure care or treatment is always provided with a view to achieving service user's preference and ensuring their needs are met is a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2009 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience
● Staff were provided with training, however, many staff needed to complete updates of specific training. The registered manager held a matrix showing when staff completed some training. Only 4 or 7 nurses had completed necessary moving and handling training, with 2 of those only having completed an online course without the practical aspect having been completed. 8 of the 23 care staff, recorded on the matrix, had not completed this training. The registered manager told us that they had their own moving and handling trainer on the staff team, so it was unclear why this training had lapsed. We were told some additional epilepsy training had been completed by staff but this information was not available to the registered manager as it was on another staff members computer and the registered manager did not have access to it.
● Some people living at the service were living with long term conditions such as dementia and diabetes. Only 4 staff had completed dementia training, only 6 staff had completed diabetes training. This meant staff were not always provided with the necessary skills and knowledge to support people living at the service.
● Staff did not receive regular one to one supervision or appraisal. This had been identified to the registered manager by the local authority Quality Assurance team in January 2022 but had not been actioned as agreed.
● The supervision matrix held by the registered manager, showed that only 1 nurse and 9 care staff had received supervision in the last year. 2 nurses and none of the care staff had received an appraisal in the last year.
● Staff did not have the opportunity to receive support, share ideas or receive information from the registered manager through regular staff meetings. One staff meeting had been held this year in August. The registered manager confirmed they did not take place often. The Quality Assurance action plan had highlighted the need for staff meetings to be held regularly. This meant staff were not adequately supported.
● The registered manager did not regularly monitor nurse's professional registration requirements with the Nursing and Midwifery Council (NMC) such as their PIN numbers. One nurse had not completed their revalidation in the allocated period, or the extension agreed, and had allowed their PIN to lapse and their name had been taken off the register. This meant they were not allowed to practice as a nurse. The registered manager was unaware of this concern. When the nurse informed the registered manager, actions were taken to have the nurse re-registered with the NMC.

The failure of the provider to ensure staff received appropriate support, training, professional development, supervision and appraisal is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2009 (Regulated Activities) 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's dietary requirements were recorded in their care plan. The kitchen staff had details of how people's meals were to be provided such as pureed or cut up. However, this information did not contain all the details of everyone's needs. For example, one person's care plan stated they were allergic to fish, and this was not recorded, and the person had been provided with fish to eat.

● Staff monitored people if they were at risk of poor nutrition and involved healthcare professionals where required. However, these monitoring records were often not fully completed and there was no one checking these records to identify gaps. This rendered the process ineffective.

The failure of the provider to maintain accurate, complete and contemporaneous records contributed to the breach of Regulation 17 (Good Governance) of the Health and Social care act 2008 (Regulated Activities) 2014.

● People were supported with their dietary needs where this was part of their plan of care. We saw staff sitting with people supporting them to eat and drink.
● People told us about the food, their comments included, "The food has gone 'downhill'. I like curry and Chinese food and now order them in, I suppose it can't be good all the time," "I mentioned I liked green tea when I first arrived, but I told staff that I didn't really mind what I drank, after a few weeks here a pack of green tea was provided to use with my own kettle to brew up when I liked. I couldn't believe the kindness shown to me, it will help me remain independent" and "Great, very good, plenty of it." Relatives comments included, "(Person's name) has a soft diet; the food is well presented and there are lots of drinks." These comments were shared with the registered manager.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff referred people to other professionals when their needs changed. This helped ensure people could get support as required from health or social care professionals. However, poor monitoring systems meant management might not have been aware of any decline in people's well-being.
● Care records showed records of visiting healthcare professionals' advice and guidance. However, as reported above, this guidance was not always followed by staff.
● People told us, "Today I was supported to see my physio at the hospital, and I was close to taking my first step, it's been a very good day" and "I was recently escorted to the local hospital for an x-ray and a staff member changed their day off to assist".

Adapting service, design, decoration to meet people's needs
● The premises were suitable for people's needs and provided people with choices about where they could spend their time.
● Access to the building was suitable for people with reduced mobility and wheelchairs. Access to the upper floor was via a passenger lift.
● The service had toilets and bathrooms with fitted equipment such as grab rails for people to use in support of their independence.
● People's rooms were personalised to their individual requirements. Rooms were full of items that were important to the person such as pictures, ornaments and cuddly toys.

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 good. At this inspection we have rated this key question 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

- During a Direct Monitoring Assessment (DMA) carried out by CQC in October 2022, it was identified that the Statement of Purpose was not covering all the service user groups that were being supported at Caritate. This meant the service was not correctly registered with CQC for all the care being provided. These concerns had not been actioned by the time we carried out this inspection.
- There was no robust internal improvement plan in place, despite one having been agreed with the local authority Quality Assurance team in January 2022. There was no effective auditing programme in place at the service. Some audits had been delegated by the registered manager to other members of staff, but the registered manager did not have the outcome of audits available to them at all times. This meant that opportunities to improve the service may have been missed.
- The oversight by the registered manager of staff training and supervision was not effective. The supervision records held by the registered manager held the names of 19 care staff, when the training matrix held the names of 23 care staff. This meant the records were not complete or accurate and oversight was not robust. Staff were not provided with regular supervision.
- The registered manager had not notified CQC of DoLS authorisations and safeguarding concerns raised to the local authority, as required. The local authority Quality Assurance team confirmed that the registered manager had been told of the need for this to be done.
- The Quality Assurance action plan from the local authority reported 'slow progress' with regards to meeting the agreed targets for the completion of necessary tasks. For example, the action plan agreed in January 2022 stated that the nurses were requesting more frequent meetings to improve communication. This had not been put in place. It was also recommended that staff meetings should be monthly with a clear agenda. The registered manager confirmed to us that meetings 'don't take place very often.' The last whole staff meeting was 25 August 2022, and this was not a clinical meeting. This meant that the registered manager had not met this required action from the agreed plan and staff were not being provided with regular opportunities to share information.
- The registered manager did not have a good understanding of the MCA legislation. Applications made by the registered manager to the DoLS team for authorisations, did not have all the necessary information provided, such as the fact the CCTV was in place in their rooms. Records did not show how decisions had been made on behalf of people who did not have capacity to make decisions for themselves. Consents had been sought from people who did not have the legal right to consent on behalf of another person.

●The registered manager had failed to work in line with government guidance. As reported in the Safe section of this report, the registered manager had agreed for all staff to stop wearing masks when working in the service. We advised them of current government guidance and the need to record any decisions not to comply with this in robust risk assessments and in collaboration with other agencies. The registered manager sent the CQC a risk assessment dated 14 November 2022. However, this did not comply with current guidance and did not give a clear rationale for staff not wearing masks. We referred the registered manager to the public health team for advice.
● Nurses professional registration details, required for them to practice, were not routinely monitored. One nurse had missed an extension deadline for their revalidation and their registration with the Nursing and Midwifery Council had lapsed. This meant they were not allowed to practice as a nurse. The registered manager was not aware of this until they were informed by the nurse.
● The registered manager had not ensured their knowledge of any developments in the care sector was up to date. They were not aware of the statutory guidance Right support, right care, right culture and were not supporting people with a learning disability in line with the principles of the guidance.

The failure of the provider to ensure that there was robust and effective oversight of the service provided is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager and the provider met regularly, and a report was provided by the registered manager for every meeting. However, this report focused mainly on maintenance, staffing levels, bed occupancy and high-level reports from each head of department such as catering and housekeeping. It did not share with the provider any feedback on the service provided, such as audits on medicines management, accidents and incidents, care plans, monitoring records, and people's views and experiences of the service provided. We found these audits were not taking place regularly, and if they were completed by other staff the registered manager did not have access to the information. This lack of oversight of the service provided has led to the breaches found at this inspection.
● Regular meetings were taking place between the registered manager and the Quality Assurance team at the local authority since January 2022. There was an action plan in place where dates for completion of agreed actions had been missed.
● The service had received support and guidance from the local learning disability team to improve people's experiences. No action had been taken to implement the advice given. We found there was a culture of low expectations for people with a learning disability. For example, the registered manager told us one person could not communicate.
● The registered manager admitted that there were 'things that needed doing' and accepted the concerns that were identified during this inspection. They took immediate action to address many of the urgent issues such as the DoLS assessments. However, we remain concerned as the service has received support from the Quality Assurance team for several months and have failed to make significant improvements .

The failure of the provider to evaluate and improve their service is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager did not always understand the duty of candour requirements and had not always ensured that information was shared with people and families. For example, when one person was moved in

to share with another person without the families knowledge.
● The registered manager had notified CQC of any deaths in line with the regulations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives were complimentary about the service. One person told us, "Staff are very good, sensitive, and professional."
Relatives comments included, "We visit regularly, it is excellent without a shadow of a doubt. We visited other homes and did not like them but Caritate was the one as soon as walked in. They keep in touch with us when needed" and "(Person's name) has been brought back to life by the care of the staff, I have observed them take great care to dress them and reassure them."
● Staff were positive about the management support provided to them. Comments included, "Yes we can get the support we need" and "(Team Leader's name) is really good and helpful," "I really love working here, we all work well together, and it is really friendly" and "It feels like a big family here." However, as reported in the Effective section of this report, formal support systems were not in place. Therefore staff needed to be proactive when asking for advice and support and would be unaware of any changes in good working practice guidance.

● Working in partnership with others
● The service had established working relationships with professionals including health and social care professionals and commissioners of care. We contacted healthcare professionals whose contact details were given to us by the registered manager however, none of them responded with their views and experiences.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care or treatment is always provided with a view to achieving service user's preference and ensuring their needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in accordance with the requirements of the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure medicines were managed in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate support, training, professional development, supervision and appraisal.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that there was robust and effective oversight of the service provided, to evaluate and improve their service and effectively assess, monitor and mitigate risks relating to the health, safety and welfare of the service users.

The enforcement action we took:

We issued a warning notice to the provider.