M & S Care Limited

Seven Gables

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Seven Gables is a residential care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Seven Gables is registered to provide care for up to 25 people, including people living with mental health needs and dementia. At the time of the inspection, there were 21 people living at the service.

People's experience of using this service and what we found.
Although people told us they felt safe, we found that people did not receive a service that ensured they were safe. Risks were not always assessed, identified and managed to meet people's needs. Care plans and risk assessments did not identify essential information to ensure people were supported in a safe way. There was a lack of provider oversight to address risks to people. Staff lacked knowledge in what their responsibilities were under safeguarding processes and as a result people were exposed to continuous risk of harm.

Medicines were not managed safely. Bathrooms and people's bedrooms were not clean, which meant there were infection control risks. Staff did not use safe practices when using personal protective equipment. Staffing levels were not sufficient to ensure people were safe and received good care. There had been a high level of staff resignations within a short timeframe. Recruitment processes were not robust which put people at risk of being supported by unsuitable staff.

People were not always shown respect and dignity when being supported by staff and there was a lack of meaningful activities that people would enjoy.

People were not 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; the policies and systems in the service did not support this practice.

The leadership of the service was impacted by the absence of management oversight or contingency planning. The provider oversight of the service had been poor. There was insufficient risk management and quality monitoring. Auditing was not robust and there were missed opportunities for learning and improving the quality of care.

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 this service was good (published 26 February 2019).

Why we inspected

We received concerns in relation to staffing levels, medicines management, food safety, accident and incident management and people's safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care services inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Seven Gables 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 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 keeping people safe, risk management, medicines, staffing numbers, staff recruitment, dignity and respect, leadership and oversight of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

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 for 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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Seven Gables

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 was completed by two inspectors on the first day, one inspector and an assistant inspector on the second day, and one inspector on the third day. Following the inspection visits, an assistant inspector made phone calls to staff and relatives.

Service and service type
Seven Gables 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. However, the registered manager was not present during this inspection period.

Notice of inspection
The inspection was carried out on 27 August 2021 was unannounced. The second and third days were carried out on 1 and 2 September 2021 and were announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback

from the local authority and external professionals who work with the service. 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 nine people who used the service and two relatives about their experience of the care provided. We spoke with nine members of staff including the nominated individual, two senior managers, senior care staff, care staff and the cook.
We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and four other staff files in relation to training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with four staff and four relatives. We continued to seek clarification from the provider to validate evidence found. We requested further evidence from the provider in relation to training, safeguarding, and quality assurance records. The provider failed to provide the requested information.

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 were not managed and mitigated effectively. Although people told us they felt staff were, "Doing their best", we found people were at risk of harm. People's care plans did not contain detailed and up to date information about their individual needs. For example, some people were cared for in bed, which placed them at high risk of skin damage. There were no care plans or risk assessments in place to provide guidance to staff on how to mitigate these risks. Staff gave us conflicting information about skin integrity risks to people. For example, a staff member told us one person had a pressure injury. However, when we reviewed the person's care plan, there was no information about this risk. We raised this with the nominated individual who made additional checks and confirmed the person did not have a pressure injury. Pressure relieving mattresses in use, were not set correctly, according to people's weight. For example, one person's care plan had their weight recorded as 62kg. However, their mattress was set for a person weighing 120kg, which placed them at risk of harm. In addition, there were no monitoring checks in place to ensure settings remained correct for each person. This placed people at increased risk of pressure injuries.

● Although people had charts in their care plans to record when they were assisted to change position, there was no information to describe how frequently this should be completed for each person. For example, we found one person's records demonstrated that over a 48-hour period, they had not been supported to change position for two periods of six-hours and seven-hours. This placed them at significant risk of developing avoidable skin damage and pressure injuries. We raised these concerns on the first day of our inspection with a senior manager, however on our arrival on the second day of our inspection, we found no adjustments or checks had been implemented to safely manage pressure relieving equipment. We raised these immediate risks with the nominated individual on the second day of our inspection, following which action was taken to address the concerns and ensure people's safety.

● People were not being supported to move safely. For example, we observed one person being pushed in a wheelchair without any footplates on, which was unsafe practice as the person could injure their feet or fall from the wheelchair. When we asked staff where the footplates were, they told us, "I don't know, we don't use them, as the wheelchair would not fit in the lift with them on." In addition, a staff member was observed pulling a person up under their armpit, which was not a safe method and could cause injury. We could not be assured that staff were using the correct equipment or safe moving and handling to support people.

● People did not always receive the support required to reduce risks around their nutritional needs. During our inspection care staff and kitchen staff told us that no-one required a soft diet. However, following our inspection, we spoke with additional staff, who contradicted this and identified four people who required a soft or pureed diet. Therefore, we could not be assured staff had the information required to keep people safe and provide food in line with associated risks. We raised this immediate risk with the nominated individual so that people's needs could be reviewed.

● Further concerns found at the inspection included a lack of information in people's care records to

describe any equipment in use and a lack of monitoring or analysis of people's weight. One staff member told us, "I do read the risk assessments as long as they are up to date, but they haven't always been updated." We raised our concerns with the nominated individual, and they told us they would take action to address these risks.

● Risks to people from the environment were not being managed safely. For example, on the first day of our inspection, we saw doors with signs on stating they should be locked, were left unlocked. One was a cupboard which contained the service's fuse box and gas boiler, another door was to a sluice room, which had disinfectant left out. In addition, we found gates in place across the top of the stairs to stop people from falling, being repeatedly left open. This placed people at risk of harm. We raised this concern with the member of the management team present on the first day of our inspection. However, we found doors were still unlocked and gates left open on the second day we visited.

The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● Risks associated with infection prevention and control were found. On the first day of our inspection, we found the environment was dirty. For example, toilets were dirty and stained, there was a toilet brush embedded with faeces and toilet paper. Sinks and bathroom floors were dirty, and the sealant around showers, sinks and toilets was worn, which made it difficult to effectively clean. People's bedroom carpets were seen with food and debris on, people's tables had crumbs and dust on, and two people's bedroom chairs were stained. The failure to ensure the home was clean and well-maintained placed people at risk of infection.

● On the second day of our inspection, we found the bathrooms and people's ensuite toilets were still dirty. The soiled toilet brush was still in a main bathroom. We discussed this with the nominated individual and senior manager, who took immediate action to address the risks and replace the toilet brush. On our third day of inspection, we observed additional staff, who were completing cleaning tasks.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was a lack of cleaning schedules to evidence that frequently touched points were cleaned at least daily. Although the provider had identified in an audit they completed on 8 August 2021, that 'touch points' were not being frequently cleaned, we found no evidence that action had been taken to mitigate the risks. There were no systems in place to ensure deep cleaning was completed and we could not find evidence of cleaning audits, to ensure robust processes were in place.

● We were not confident that staff understood how to use personal protective equipment [PPE], effectively and safely. One staff member told us, "We've only been told we must wear PPE and wash our hands; we haven't actually had any training (in PPE)." Throughout our inspection we observed multiple staff wearing their masks incorrectly. We addressed this with them at the time and informed the nominated individual and senior manager, who told us they would address this with the staff team. Not using PPE correctly increased the potential risk of the spread of health infections.

Infection prevention control systems were not robust enough to mitigate the risk of people being safe from infections. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff confirmed and we observed that they had access to PPE, although staff were not always using this correctly.

● Staff had received some training in IPC and COVID 19 management, although we were unable to

determine from records if all staff had received this.
● We observed staff were following guidance when visitors came to the service. Covid testing was being carried out as required, although we could not be assured this had been consistently completed as records were unavailable for us to review. We discussed this with the nominated individual and senior manager who gave us reassurances that testing was being completed for staff and people living in the service, in line with government guidance.
● The provider assured us they were was meeting shielding and social distancing rules. However, we did not observe people or staff social distancing from each other.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
●There were not enough staff to meet people's needs and ensure safe care was provided. On the first day of our inspection we found there were only two care staff on to support 20 people in the service. Although, we were told a third member of staff had been working to assist to get people up prior to our arrival. Staff told us there were often only two of them on each shift, and they felt it was unsafe.
● 10 people living in the service required two staff to support them with safe moving. There were not enough staff to support them, whist being available for other people. We discussed this with the nominated individual on the first day of the inspection and as a result of our concerns, were given assurances that agency staff had been sourced to support the service, until additional staff could be recruited.
● Staff were not deployed in a way that prioritised people's needs and safety. We observed, where people required some care and support to cut their food, to ensure they had drinks and to be encouraged and supported to eat their meals, staff were not available to do so.
● On the first day of the inspection an inspector had to intervene to support people in the dining room with their meals and give them drinks to ensure people's safety. Another person who was at risk of falling, attempted to stand in the lounge on their own. A third person asked to go to the toilet, expressing their distress to staff and the immediacy of their need. Staff told the person they would have to wait.
● Staffing levels had improved by our second and third inspection visits, however, we still observed people not receiving the care and support they required in a timely way and staff were task focussed.

The failure to supply sufficient numbers of qualified, competent skilled staff was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity)
Regulations 2014.

● Staff had not always been safely recruited. For example, we found one staff member had no evidence of a recruitment process being followed and no evidence to demonstrate a DBS had been applied for. DBS checks enable employers to check the criminal records of potential employees and are important to enable them to make safer recruitment decisions.
● We reviewed four other staff recruitment records. Three out of the four records reviewed had missing evidence in line with the requirements of Schedule 3 of the Health and Social Care Act 2008. Two staff only had one reference on their file, when two are required. The third staff file had no photographic identification and no record of the required checks for a criminal record that would need to be completed prior to working with vulnerable adults. This meant we could not be assured that safe recruitment practice was followed, meaning unsuitable staff could be employed to care for people.

The failure to ensure fit and proper persons were employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

Using medicines safely

● Medicines were not managed safely. We identified multiple discrepancies between the number of tablets people should have had in stock, according to when the monthly medicines administration cycle commenced and the number of tablets we found. Systems to record how many tablets had been received into the service could not be located. This meant it was not possible to determine if people had been under or overmedicated and we could not be assured there were safe systems for ensuring people received their prescribed medicines.

● Medicines that required extra control by law and additional storage and administration measures, due to the high risks they pose, had not been logged into the appropriate records system in accordance with the legal requirements. We found three medicines had not been logged into the records book, when they were received into the service. This meant we could not be assured that safe systems were in place to store and administer these types of medicines.

● Where people were prescribed topical medicines, we could not find evidence these were consistently applied as prescribed. We found topical creams in people's bedrooms with no labels of when they were opened or when they should be disposed of. In addition, some topical creams that were out of date, appeared to be still in use. We raised this concern with a senior manager on the first day of our inspection, however we found that on our second visit, these creams were still in people's bedrooms.

● People's medicines that were prescribed, 'as and when required' [PRN], were not safely managed. People did not have clear PRN protocols to inform staff how the person may present if they required their prescribed PRN medicine.

● Information about any potential side effects of medicines prescribed and what staff should monitor, was not always in the electronic MAR record or people's care plans. This meant people were at risk from staff not recognising potential signs and symptoms of reactions to their prescribed medicines.

● There was a lack of staff understanding about medicines systems to ensure medicines were ordered, stored and administered safely. We found that the registered persons who had responsibility to ensure safe medicines practice was followed, had not ensured staff had the skills and knowledge to support safe medicines administration and management, in their absence. This placed people at risk of harm. We raised these concerns with the nominated individual who arranged for the provider's area manager to take responsibility for medicines management, until safe systems were in place.

The failure to ensure risks relating to the management and administration of medicines was safe, was a 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; Learning lessons when things go wrong

● There was a lack of evidence to demonstrate if accidents, incidents and safeguarding events were recognised, recorded or if action was taken where required. For example, one person had fallen out of bed during the night and this was unwitnessed. An accident record had been completed. However, as the person lacked capacity to say what had happened, staff could not be sure if the person had hit their head. We could not find records to demonstrate if the staff had followed best practice guidance and monitored the person regularly for signs of deterioration from a head injury.

● The provider was unable to demonstrate if accidents, incidents and safeguarding events were analysed to identify if any themes or trends were occurring. We could therefore not be assured if action would be taken to address any recurring patterns.

● Staff told us they understood how to recognise abuse and what to do about it. One said, "I'd report concerns to management, I guess. I'd go further up the chain and report it to [local authority] safeguarding."

During our inspection, staff identified they felt people had been at risk of harm for some time. However, they had failed to follow the provider's safeguarding processes and as a result people were exposed to continuous risk of harm.

- There had been some recent safeguarding concerns raised with the provider through the local authority. We found the provider was taking action to address these concerns.
- The provider had an up to date safeguarding policy in place.
- We were unable to determine if all staff had received safeguarding training due to the records not being available. However, we were able to access four out of 25 staff members training records and they had received safeguarding training.

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 good. At this inspection this key question has now deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People were not always shown dignity or respect. We observed an undignified culture in the service where staff were task focussed and had little time to spend with people. Staff described supporting people to eat or to use the toilet as, 'doing the feeders' or 'toileting'. This was not dignified or person-centred language when describing the support people needed. In addition, we observed a staff member approach a person whose trousers were undone. They took hold of the person's trousers and did them up and walked away again, without speaking to the person at any point.

● During the lunchtimes we observed, people were told by staff the plates were very hot. Staff then walked away and left people with no support. When a person touched the plate and exclaimed it was hot, a staff member who had briefly returned to the room said, 'Well I told you not to touch it'. This demonstrated a lack of care and people were not treated with dignity and respect.

● People had become accustomed to staff not supporting them. We found core staff were rushed or dismissive of people. One person told us they liked to watch television, but there were never any staff available to put the television on for them. They asked a member of the inspection team to come back later in the day to put their favourite programme on. The person told us, "The staff never come back to do it, when I ask them." We returned to ensure the person had their programme to watch. Another person, when asked if they used their call bell to get support told us, "There is no point pressing that, they never come."

The failure to ensure dignified and respectful care delivery at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, the agency staff that had been brought in to support the service following our first day of inspection, were kind and compassionate and we observed some lovely interaction between them and people. We raised our concerns about the home's permanent staff with the nominated individual and senior staff.

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

● At the time of our inspection the registered manager was not working in the service and the provider was unable to demonstrate they had robust oversight of the systems and processes within the service and of the registered managers responsibilities, to ensure safe care was provided. For example, audits completed by the registered manager during July 2021, stated that care plans were up to date and information about

people's medicines needs was clearly recorded, however this was not the case. Environmental audits completed were poor and did not contain detail that enabled risks to be identified earlier and action taken where required.

● In the weeks immediately prior to the inspection there had been no consistent provider level oversight in the absence of the registered manager. In addition, the deputy manager had resigned and left the service. The responsibilities of these roles had fallen on staff left in charge, who had not worked in these roles previously and lacked the required skills and knowledge. Although there had been some provider level oversight, this had not been consistent or effective. For example, an audit had been completed on 8 August 2021 by a senior manager, where they identified some of the concerns we found. However, the provider was unable to demonstrate any action had been taken to address the immediate risks. The providers failure to take prompt action meant people remained at significant risk of harm.

● Several staff had resigned, with some having already left and some due to finish employment in the next couple of weeks. One staff member said, "I'm shocked at the level of deterioration, we've lost a lot of staff we have had no support from the [registered] manager who wasn't here full time." We found that robust action taken to address the immediate risks to people resulting from a lack of staff had not been effectively implemented. On the first day of our inspection when we found two care staff supporting 20 people, 10 of which required two staff to support them for some or all aspects of their care needs. We raised immediate and significant concerns about people's safety with the nominated individual. As a result, they and the senior management team took action and were able to source some agency staff to work in the service until further care staff could be recruited, which mitigated some of the risks.

● We requested some additional information from the provider including staff rotas for weeks commencing 6 September 2021 to the week commencing 20 September 2021. We requested records of complaints or compliments received, the provider's statement of purpose, minutes of staff meetings, minutes of resident's meetings, safeguarding records and staff training records. We have not received this information to date. The failure to be able to provide information demonstrates the provider had not ensured safe systems and processes were in place for the running of the service.

● Effective systems were not in place to allow continuous learning and improving care. For example, we could not find evidence to demonstrate accidents and incidents had been robustly investigated to identify further risks or triggers or prevent recurrence and to help ensure people's safety.

● The provider had a business continuity plan in place. However, this had not been updated to reflect the COVID-19 pandemic to plan for staff absences due to illness or needing to self-isolate. The list of staff contained in this record were also out of date and therefore this plan was ineffective.

The failure to operate effective systems to assess, monitor and ensure the quality of the service was a breach of Regulation 17 of the health and Social care Act 2008 (regulated Activities) Regulations 2014

● When concerns were raised with the nominated individual and senior manager during the inspection, they were responsive and took action to address immediate concerns. Following the inspection an action plan was received from the provider, outlining the issues and concerns found during the inspection and from local authority staff feedback. This demonstrated how they planned to address the concerns and improve safety.

● We viewed four staff training files and saw evidence these staff had received training during 2020 and 2021. However, we were unable to view all staff training to be able to determine if they had received training as required.

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

● People told us the staff were too busy to support them. They felt like they couldn't ask for help as staff

would not come and they appeared despondent. One person when asked if they used their call bell said, "It's never any less than an hour [for staff to come]. I suppose you can't expect them [staff] to come straight away, but quicker than they do would be good." Another told us, they felt anxious and "miserable" most of the time. A third person told us, they were, "Fed up of being stuck in my chair". We moved their call bell into reach before leaving their room and they said, "There's no point in me using that, they [staff] won't come."

● Staff were clearly unhappy and the atmosphere in the service appeared tense as a result. Staff were openly discussing with people that they were leaving. There appeared to be no thought to the impact this might be having on people's wellbeing. One staff member said, "This used to be the best home and staff were really dedicated, now the staff are all leaving." Another said, "Everyone [staff] seems a bit fed up, but it's more that it's not fair for the residents."

● There was a supervisions policy in place, but it was unclear if staff had received regular supervision and support as the provider was unable to find records to confirm this. A staff meeting had taken place in on 1 September 2021, where staff could share their views and discuss plans the provider had to improve the service and support staff development.

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

● There was a closed culture within the home. People, relatives and staff were not confident who to raise concerns with or that any issues or concerns they would be listened to or acted upon. We asked people if they felt they could raise concerns with staff or management. One person said, "They [staff] do what they want. Not really, they might listen now and again, but they don't pay no notice to what I say." A relative told us, "A couple of staff that work with my [relative] have been a bit rough with [person] and a bit abrupt. I don't think it was anything to raise a complaint about, but I spoke to a couple of staff about it as they made my [relative] feel a little bit anxious." The provider was unable to find any records that showed staff had reported these concerns to the registered manager or provider.

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. However, the provider was unable to locate records to demonstrate if this was applied as required.

● The provider was also unable to find evidence to support complaints were investigated thoroughly, or action taken where required. For example, we could not be assured that action had been taken in line with best practice following a complaint made to the service by a relative in April 2021.

Working in partnership with others

● The registered manager and staff worked in partnership with local health professionals, however, it was unclear from records that staff recognised when they needed to seek support.

● Healthcare professionals visited the home regularly and one had raised concerns about the care people were receiving and their safety with the local authority, which in part prompted our inspection.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered persons had failed to ensure people were treated with dignity and respect

The enforcement action we took:

We have told the provider they must send an action plan every month to tell us about the improvements they are making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to ensure risks to people, the environment, infection control processes and medicines were managed safely.

The enforcement action we took:

We have told the provider they must send an action plan every month to tell us about the improvements they are making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to operate effective systems to assess, monitor and ensure the quality of the service

The enforcement action we took:

We have told the provider they must send an action plan every month to tell us about the improvements they are making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons had failed to ensure there were safe recruitment processes to ensure fit and proper persons were employed.

The enforcement action we took:

We have told the provider they must send an action plan every month to tell us about the improvements they are making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to ensure there were sufficient staff available to keep people safe and meet their assessed needs.

The enforcement action we took:

We have told the provider they must send an action plan every month to tell us about the improvements they are making.