Minster Care Management Limited

Saffron House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Saffron House is a residential care home providing personal care to up to 48 people. The service provides support to people living with dementia, a physical disability, older people and younger adults. At the time of our inspection there were 33 people using the service. The home accommodates people across 2 floors in 1 building.

People's experience of using this service and what we found
People were not kept safe from known risks. Where risks were identified there was not always guidance to inform staff how to support people safely and consistently. Action had not been taken to reduce fire risks. Medicines were not managed safely which exposed people to the risk of harm. Infection prevention and control measures were not robust, and some areas of the service were visibly dirty, unhygienic and malodorous.

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. People's nutritional and hydration needs were generally met although people's dining experiences were varied.

People's choice and dignity was not always maintained. Communal bathrooms and toilets were locked, meaning people could not easily access them when needed. Relatives told us about personal items going missing at the service. People were left to sleep in unclean mattresses and bedding.

Systems and processes to ensure good oversight of the service were ineffective. When we raised concerns during the inspection, further action was taken by the management team – for example replacing soiled mattresses and arranging staff training. People were at risk of receiving care that did not meet their needs or wishes. Records were either inaccurate or lacked detail to provide staff with guidance on how to support people appropriately.

People's communication needs were met. People were able to engage in activities at the home. Staff felt supported within their roles and told us they received regular supervision and meetings. Staff were recruited safely.

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 (21 January 2021).

Why we inspected
The inspection was prompted in part due to concerns received about infection control and staffing. We

made a decision to inspect and consider risks at the service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 Saffron House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to consent, safe care and treatment, safeguarding and governance at this inspection.

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.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Saffron 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
This inspection was carried out by 2 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
Saffron House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Saffron House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
Not everyone who lived at the home was able to share their views with us. As a result of this, we spent time observing interactions between people and the staff supporting them. We spoke with 6 people who used the service and 3 relatives about their experience of the care provided.

We spoke with 14 members of staff including the registered manager, regional manager, 2 senior care workers, 6 care workers, maintenance, domestic staff and cook. We looked at a range of documents including people's care plans and risk assessments, staff recruitment records, training records, DoLS records and mental capacity assessments. We also reviewed audits and governance, medicines records and observed medicine administration. We conducted checks of the building, grounds and equipment.

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. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● The provider failed to provide a clean, hygienic, and well-maintained environment for the people living at the service. We identified significant failings with the cleanliness and upkeep of people's living accommodation, including commode bowls not being cleaned thoroughly, unclean toilet pans, ingrained dirt in wooden doors, splatter marks and stains on walls, and 1 person had crash mats that were unclean and ripped. A large number of people's bedrooms and areas of the corridors had strong and unpleasant smells.

● We identified multiple mattresses which were heavily soiled and foul smelling. The registered manager had noted that 1 person's mattress was not fit for purpose in April 2023, however, had allowed the person to continue to sleep on the malodourous and soiled mattress until our inspection.

● People's bedding was stained and worn. We identified pillows with heavy staining, and duvets which were ripped and had holes in the inner cover. Staff regularly changed people's bed sheets, pillowcases and duvet covers, meaning they saw the poor condition these items were in, however allowed people to continue to sleep with substandard bedding until our inspection.

● Areas of the service were in a state of disrepair. For example, handrails and door frames had chipped paintwork exposing porous wood. This meant areas around the home could not be thoroughly cleaned or sanitised. This left people at risk of cross infection.

●People were not protected from water borne infections. We found a build-up of limescale on multiple taps around the service. Limescale deposits can be a breeding ground for dangerous bacteria including Legionella bacteria which causes Legionnaires' disease. Records referenced shower-head descaling but did not record any descaling of tap outlets.

● Cleaning schedules and records of cleaning were not always completed or regularly monitored.

The provider had failed to protect people from the risk of infection. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On CQC intervention, the provider took action to improve infection prevention and control practices at the service and replaced all damaged bedding and mattresses.

Assessing risk, safety monitoring and management

● Risks to people were not managed safely and proactively. Some people were at risk of harm in the event of an emergency because their evacuation plans were not reflective of their needs. One person's Personal Emergency Evacuation Plan (PEEP) detailed that they resided on the first floor but did not record whether the person was able to use the stairs.

● Another person's PEEP recorded that they required the assistance of 2 staff and an evacuation sledge

during an evacuation but did not provide guidance on how to safely do this. Staff we spoke with gave us different answers on how they would use the evacuation sledge, and some staff reported they had not received practical training on how to use the sledge. This put people at significant risk of harm in the event of a fire or other emergency as staff did not have the skills or information to be able to evacuate all people safely.

● Some people had been assessed as being at risk of choking. Speech and Language assessments indicated that they needed modified foods and fluids. Guidelines for staff were not consistently followed. For example, 1 person who required a modified diet, had it recorded in their care plan that they must be sat fully upright when being assisted with their meal. However, during the lunchtime meal, this person was observed to be assisted with their food while lying almost flat in bed. A staff member advised that the person was often laying down whilst being assisted to eat. This greatly increased the risk of the person choking.

● Care plans did not contain sufficient information to reflect people's mental health and emotional needs. For example, 1 person was known to express agitation that could result in injury to themselves, others around them, or staff. The person's care plan did not describe these risks, nor provide guidance for staff on known triggers, and ways to support the person when they were in an agitated state.

We found evidence that systems were not sufficiently effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection the registered manager has put plans into place to improve care records, risk assessments, and provide practical training for staff on fire evacuation.

Learning lessons when things go wrong

● Known risks were not acted upon. A fire risk assessment carried out in 2021 identified the unlocked external bin store was an arson risk. This bin store remained unlocked during our inspection.

● Incident analysis was not always effective. Incident analysis of falls did not always identify all incidents that had occurred. For example, 1 person who was known to be at risk of falls had a fall in April 2023 and again during our inspection. However these were not recorded or analysed on their falls incident analysis record. This impacted the providers ability to identify themes and trends to mitigate future risks.

The provider failed to take action to improve the safety of the service. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not managed safely. This placed people at risk of harm because staff were not consistently administering all prescribed medicines in line with national guidelines.

● Transdermal patch (medicines applied directly to the skin through an adhesive patch) records were not completed consistently. Records were not always completed to confirm the location of the new patch or that the old patches were removed before applying the new ones. This meant we could not be assured the patch was rotated on different areas of the person's body appropriately. This placed people at risk of over absorption and potential overdose. We also identified there were no daily checks to ensure the patches were still in place. This is important so other staff can check that the patch is still in place and correctly applied. If the patch is not still in place, then the person would stop receiving the dose of medicine.

● Topical medicines were not always accompanied by a body map. This was not in line with national guidelines for managing medicines in care homes. This meant people were at risk of having the cream applied to the incorrect area of the body, rendering it ineffective to the area which required the cream.

● Where people were supported with PRN (as required) medicines, staff did not consistently record the

reason or outcome of administration. This meant the effectiveness of the medicine could not always be reviewed.
● Tubs of creams and lotions had not always been dated when opened. This meant staff would not know when the contents had expired.

The provider failed to ensure medicines were managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) 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 failed to take reasonable steps to ensure that people were not subjected to any form of degradation. During inspection, we identified that communal toilets, bathrooms, and shower rooms were locked. This meant that people who were able to independently manage their continence and bathing needs had to request access to the bathroom facilities when they used communal areas of the service. This took away people's independence and risked people experiencing an episode of incontinence waiting for staff to unlock the door or having to walk further than necessary to get to their own en-suite toilet. When we asked a staff member why the communal toilets, bathrooms and shower rooms were locked they told us this was because "People with dementia may wander in there and hurt themselves." There was no evidence the provider had completed assessments in relation to this, and had instead, resorted to blanket restrictions which impacted all people living at the service.
● Staff told us they understood their roles and responsibilities in relation to safeguarding. A staff member told us if they thought someone was at risk of abuse, they would report this immediately to the relevant agencies. However, there was no evidence to suggest staff members had identified the locking of communal toilets, bathrooms and shower rooms as degrading and reported this.

Systems and processes in place to protect people's human rights were not effective. This was a breach of Regulation 13(4) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives felt they/their family member were safe using the service. One person told us, "I do feel safe, the carers are always about checking on you. I'd give the home 8/10." A relative said, "I think [Person] is very safe here."

Staffing and recruitment
● There were not enough staff to keep people safe and meet their needs. Staffing levels at night put people at risk. Only 2 staff members were allocated per floor each night, however there were multiple people who required the assistance of 2 staff members to support them. This meant at times when any of these people were supported, the rest of the people on the floor were not supervised sufficiently to ensure they remained safe. One person told us, "They [staff] take much longer at night, they don't explain the delay. They are much quicker in the day only take about three minutes."
● We received mixed feedback on staffing levels. Most people told us they felt there were enough staff, but relatives said they felt the service was short staffed.
● The provider followed safe recruitment practices. A check with the Disclosure and Barring Service (DBS) was carried out on all applicants. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes
● The provider's approach to visitors in the care home was in line with government guidance and people

were supported to have visitors.

● We observed visitors entering the home throughout the inspection and were seen spending time with their family members in the lounge and dining areas.

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 the rating has changed to 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.

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 found the service was not working within the principles of the MCA.
- Where people lacked capacity to make decisions, mental capacity assessments were not always completed. For example, 1 person's care record detailed that an external social care professional had assessed the person as not having mental capacity in 2021. However, no mental capacity assessment had been completed by the staff at the service for this person.
- Best interests' decisions were not consistently completed. Where best interests' decisions were in place, they were not always completed adequately and did not include other people in decision making. We found 1 person's care record did not contain a best interests' decision despite being assessed as not having capacity to make decisions for themselves. There was no evidence that staff had sought support from healthcare professionals to ensure decisions were made in a person's best interest with the relevant stakeholders. This meant staff may not know how best to support the person in their best interests.

Effective systems were not in place to ensure people's rights were maintained under the Mental Capacity Act. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people required lawful authorisations to deprive them of their liberty, there were not effective processes to monitor and follow up on the process of applications. For example, staff had filled in application paperwork for 1 person, however this had not been received by the local authority. This had not been identified or chased up by the registered manager. This meant the person had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority.
● Another person's authorisation was due to expire soon. The existing DoLS paperwork stipulated that a new application must be submitted at least 28 days prior to expiry of the authorisation. We identified the current DoLS authorisation was due to expire in less than 28 days and the provider had failed to submit a new application. This lack of oversight further demonstrated that people's human rights were not being upheld and reviewed in a timely manner.
● Whilst staff training records showed staff had received safeguarding training, the provider's safeguarding policies and procedures had not been fully embedded. This resulted in the above concerns not being identified and addressed.

Systems and processes in place to protect people's human rights were not effective. This was a breach of Regulation 13(5) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always appropriately assessed and their needs were not clearly reflected within their care plans. Information contained in people's care plans was not clear and some information was contradictory. This placed people at risk of not having their needs met.
● Advice and guidance provided by health care professionals was not always incorporated or available in people's care plans.

Supporting people to eat and drink enough to maintain a balanced diet
● People were offered a choice of food. However, we observed during 1 lunchtime 5 people were given drinks without a choice being offered and were given their desserts before they had finished their main meal.
● We received a mixed response about the quality, choice, and availability of food. One person told us, "I like the food here." Another person said, "You don't get a meal choice. I have mentioned it sometimes, the meat is not good, I only eat some of it."

Adapting service, design, decoration to meet people's needs
● Daily boards had not been updated to support people to understand the date, time and meal options for each day.
● People appeared comfortable in their environment and spent time in their own rooms, communal areas, and the front garden. People had their possessions and own toiletries in their rooms.
● People had access to specialised equipment like hoists to ensure they could mobilise when needed.

Staff support: induction, training, skills and experience
● Staff were being supported to receive online and practical training relevant to their roles, but training was not always up to date. For example, most staff we spoke with told us they had not received practical training on the use of fire evacuation sledges.
● Staff received an induction and ongoing opportunities to discuss their work, training and development needs. One staff member told us, "I had a good induction, with a lot of training and shadowing other staff." We also saw records that confirmed the registered manager had completed staff competencies.
● Staff told us they felt supported, and management were approachable.

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

● Staff supported people to see health professionals such as GP's and nurses if this support was necessary. However, advice from health professionals was not always recorded in people's care plans.

● People told us they had access to health and social care professionals as needed. One person told us, "I have had a couple of falls in my room, I was using my walker. They came very quickly. The paramedics came and looked after me."

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People's needs and preferences for independence were not always met or considered. For example, 1 person smoked and required the assistance of staff to take them outside for a cigarette. However, there were no staff provisions put into place for this and staff did not record when they supported this person with a cigarette. This restricted the person from being able to have choice and control over when they smoked.
- People's dignity had not always been promoted. Relatives we spoke with told us about issues they had encountered with the laundry and their relative's personal items going missing. One relative told us, "[Person's] things can go missing in the wash." Another relative said, "Things go missing, never to be seen again."

Ensuring people are well treated and supported; respecting equality and diversity

- Most people and relatives spoke positively about staff and the care they received. One person said, "They [care staff] all seem very cheerful and get on with their jobs." One relative told us, "There's always staff around, I think [Person's] care is good here." However, 1 person said, "Sometimes they are a bit short with me, but it doesn't affect me."
- Staff interaction was kind and caring. We observed staff spoke with people respectfully.
- The provider had an equality policy and staff had received training in equality and diversity. This helped staff care for people's unique needs with respect.

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

- Records did not always evidence how people were supported to be involved in making decisions about their care.
- Meetings for people who lived in the home were used as a forum for people to express their views about the service. Some people told us they were not aware of meetings. One person said, "I don't know of any meetings." The minutes of the meetings showed those who had attended gave positive feedback and suggestions to things such as menu choices and activities.
- Staff asked people's permission before engaging in care tasks. For example, staff asked a person where they would like to sit in the lounge and supported them to get there.

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 good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- Care records were not always up to date to reflect their personalised needs. Reviews of people's care records failed to identify when their needs changed, which meant records did not show the care and support people required. For example, we saw 1 person's care plan had been reviewed the day after their GP had changed the treatment and monitoring of their diabetes, however their care plan was not updated to reflect this. This lack of guidance can impact staff's understanding of how to support people and their health needs.
- Staff told us they were not always given sufficient time to read people's care plans. One staff member said, "I'd like to have time to read them [care plans] but as of yet I don't have the time. But I do know it's important to get to know the residents and their families."

End of life care and support

- People approaching the end of their life did not have adequate care plan guidance to support their care in a way that met their needs, wishes and preferences. End of life care plans were generic in detail and task focused. For example, 1 person's care plan did not provide information on the person's preferences, support required, and medicines prescribed to ensure they would be provided in good time. It was also unclear what involvement the person and their family had in the development of the care plan.
- Staff were aware of the importance of providing good end of life care. One staff member told us, "End of life care is about giving someone comfort, pain relief, dignity and respect."
- Information about practical arrangements and decisions regarding resuscitation were recorded within the care records.

Improving care quality in response to complaints or concerns

- People and relatives told us they knew how to complain. We reviewed the provider's complaints file during the inspection and found that some complaints had been made. Whilst these had been responded to by the registered manager and mostly resolved we did identify 1 which had not been dealt with to the complainant's satisfaction. This was in the process of being reviewed again by the provider.
- We reviewed the minutes of meetings held with people who lived at the service and found people were given the opportunity to raise concerns as a regular agenda item. We also saw that when concerns were raised, management would discuss this with staff during meetings.
- There was a complaints policy and procedure in place.

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 carers, 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 care plans contained information regarding their communication needs. For example, 1 person's care plan detailed how they had previously had problems with their hearing, and provided staff with guidance on when to seek medical attention if their hearing was to deteriorate.
● The registered manager told us how they provided alternative communication aids such as picture cards, white boards, and easy read if they were required.
● Staff were seen to communicate with people in a way they understood.

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
● The activity coordinator supported people to participate in activities, this included spending time in the garden, and playing board games. One relative told us, "They [staff member] do a lot of special activities and gets [person] gardening, they asked me [Person's] favourite things."
● Animal therapy was at the home on the day that we inspected. This is where animals are brought round to people to engage with. We saw people had a positive reaction to this.
● Staff supported people to maintain links with those that are important to them. People were supported to maintain regular contact with their families in person or remotely via telephone or video calls.

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. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The registered manager and provider had failed to ensure the quality assurance systems were reliable, robust and effective to drive improvements. The lack of governance meant the issues found at this inspection around the environment, infection prevention and control and risk management had not been identified or rectified in a timely way.
- Governance and quality monitoring systems had failed in assessing, monitoring and mitigating potential risks to people's safety, as evidenced by not identifying environmental and fire safety risks and risk management. For example, the build-up of limescale on multiple taps around the service and the lack of descaling was not identified by the provider. A mattress check carried out by the registered manager identified that 1 of the mattresses was heavily soiled and foul smelling in April 2023 but failed to act on these findings. The failure to have effective systems significantly restricted the ability to identify risks and address shortfalls, exposing people to the risk of avoidable harm and poor-quality care.
- Quality assurance tools failed to identify that medicines were not being managed safely. For example, medicines audits had failed to identify the location of transdermal patches had not been recorded and topical medicines were not always accompanied by a body map. This placed people at risk of harm from receiving medicines incorrectly.
- Quality assurance tools failed to identify that risk assessments were not always in place, and care plans were not updated appropriately or detailed enough for people to receive person-centred care. For example, we saw care records for 2 people who were at risk of choking contained contradictory information regarding their modified diet. In addition, 1 of these people did not have a choking risk assessment in place. Monthly reviews of these records had been carried out and failed to identify these concerns. This meant people were at increased risk of choking.
- People were at increased risk from the spread of infection because infection prevention and control measures were not always implemented. Where concerns had been identified in infection control audits these had not always been acted upon. For example, audits carried out identified people's bedding was stained and in need of replacement in April 2023, and the unlocked external clinical waste bin had been identified in May 2023. However, no actions were taken to rectify these concerns putting people at increased risk of infection.

The failure to operate effective systems to assess, monitor and improve the service and to maintain an accurate, complete record in respect of each service user was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● While some action taken in response to the inspection was positive, the provider did not always make the necessary improvements to the quality of care. For example, we requested people's care plans were updated to provide suitable guidance for staff. Some updates completed were still not of a suitable standard.
● We discussed the areas of concerns within care records, infection control, environment, and governance with the management team. They responded to the concerns identified and demonstrated they were committed to driving improvement in the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not always supported in the least restrictive way. As detailed in effective people were subjected to blanket restrictive practices due to ineffective systems in place to identify and support least restrictive options.
● People's care records were not always up to date or person-centred and it was not clear how they and their relatives were involved in their care plans.
● People's feedback of living at the service was mostly positive. One person told us, "I'm quite happy here." Another person said, "It's a nice atmosphere here, they like to have a chat." However, another person said, "I wouldn't recommend living here, I don't know why."
● Staff were given opportunities to raise concerns during supervision and staff meetings. One staff member told us, "They [meetings] are useful as any concerns I can bring them up in the meeting."

Working in partnership with others
● Health professionals visited the service regularly. Whilst recommendations made to support people with their health conditions were implemented, these were not consistently recorded in people's care plans. For example, a GP had changed the treatment and monitoring of a person's diabetes. However, the lack of up-to-date guidance for staff put this person at increased risk.
● Records showed staff made referrals to health professionals. We spoke to 1 visiting health care professional who commented that a person's pressure sore had almost fully healed due to the care staff's ongoing care.

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 understood the requirements of duty of candour and were able to describe when and how this would be followed.
● The service is legally required to notify us of certain events that happen. We have been notified as expected.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Records showed people attended regular meetings, to share feedback and express their views on the running of the service, including developing menus and the activity programme.
● Staff told us that they enjoyed working at the service and felt supported by their peers and the management team. One staff member said, "[Manager] is very supportive, if I have any problems, they try to sort them out." Another staff member told us, "We all get on great and work well as a team."

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 11 HSCA RA Regulations 2014 Need for consent People's mental capacity was not always assessed in line with the Mental Capacity Act (2005). This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and process in place to protect people's human rights in relation to their DoLS were not effective. Systems and processes put people at risk of improper treatment while receiving care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risk of infection. Systems were not sufficiently effective to assess, monitor and mitigate risks to health, safety and welfare of people using the service. Medicines were not managed safely.

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the service and to maintain an accurate, complete record in respect of each service

The enforcement action we took:

Warning notice.