

Barkat House

# Barkat House Residential 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 caring?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Inadequate** ●

# Summary of findings

## Overall summary

### About the service

Barkat House Residential Home is a residential care home providing personal care to 26 people predominantly aged 65 and over at the time of the inspection. The service can support up to 27 people.

The care home accommodates people over two floors which were accessed by a lift in one adapted building. It provides care to older people, some of whom are living with dementia and mental health needs.

### People's experience of using this service and what we found

Although people told us they felt safe, risks to people's safety had not always been assessed and mitigated against. There was a continued failure to ensure all people's risks were identified and managed well.

Environmental risks, included and not limited to, fire safety, food safety, access and security and infection control were identified which did not always ensure people's safety. People told us there were enough staff to support them. People generally received their medicines as prescribed.

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. Whilst staff told us they received regular training, the manager and the systems in place could not confirm this. Generally, people told us they enjoyed their meals but were not involved in the planning of the menus. People's health care records did not contain sufficient information and guidance for staff to follow. The design and décor of the service failed to show regard for all people's individual needs.

People told us they were treated with kindness and compassion. However, we found concerns that, on occasions, compromised people's dignity, respect and positive experiences.

People did not receive personalised care that was responsive to their needs. People were not given information in an accessible way, so it was easier for them to understand. People told us they did not contribute to the planning and reviewing of their care. People we spoke with told us they were bored because there was a lack of social activities. People we spoke with knew how to raise a concern or make a complaint.

The registered provider had not established all the systems and processes that were necessary to operate, monitor and evaluate the operation of the service. The provider did not carry out robust checks to ensure care was being delivered safely and effectively. Whilst people's views about the quality of care had been sought there was no system in place to evidence the feedback had been acted upon. People and staff told us the provider and manager were approachable.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection (and update)

The last rating for this service was Requires Improvement (published 31 January 2019). The provider

completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement for the last two consecutive inspections.

#### Why we inspected

This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

#### Enforcement

We have identified breaches in relation to the failure to ensure all peoples risks were assessed and mitigated against, the failure to ensure people had consented to some aspects of their care, the failure to ensure people received person-centred care and support that met their needs and personal preferences and the failure to operate effective systems and processes to assess, monitor and improve the quality and safety of the service 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.

#### Follow up

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

## 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 always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### 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** ●

# Barkat House Residential Home

## **Detailed findings**

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

#### Inspection team

The inspection team consisted of two inspectors on day one and one inspector on day two.

#### Service and service type

Barkat House Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

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 reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the

views of the public about health and social care services in England. This information helps support our inspections. We used all of this information to plan our inspection.

#### During the inspection

We spoke with six people who used the service and five relatives about their experiences of the care provided. We spoke with seven members of staff including the nominated individual, acting manager, senior care workers, care workers and kitchen staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with two visiting healthcare professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance and health and safety records. The provider implemented immediate systems to address the concerns found during the inspection.

# 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 requires improvement. At this inspection this key question has remained the same. 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.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- At our last inspection, we found there was unrestricted access between the home and some privately-owned flats which were part of the same building. At this inspection we were concerned there was a continued access and security risk on the ground and first floors of the home. As a result of our concerns we took immediate action and requested that the access and security risks were mitigated to protect people from harm. We returned back to the service and saw the access risk had been mitigated.
- At our last inspection we identified concerns around fire safety. At this inspection we were concerned there were continued risks around fire safety. We saw significant fire risks in the communal garden area. This included a build-up of flammable materials such as chairs, loose rubbish, plastic bowl full of cigarette ends and old fridges. Staff we spoke with told us they had participated in fire drills but could not remember when and there were no records completed to evidence this. The provider told us night members of staff had not participated in fire drills, despite this being a recommendation in the fire risk assessment. We had to intervene and request the provider undertook urgent fire drills with all of the staff. Following our inspection, the provider told us all staff had participated in a fire drills and future drills would be undertaken on a regular basis.
- We found three cans of shaving foam being stored in a communal toilet. These products present a serious risk to people if they are ingested inappropriately. People who were living with dementia were able to access this room freely and would not recognise the dangers. These were removed on the day of the inspection.
- People were not protected from the risk of cross infection. We saw the underside of a toilet seat in one communal area had dried faeces on it. We saw a number of dirty toilet brushes in communal bathrooms. We found one person's bedroom to be offensive smelling and their bed lining was soiled. This placed people at risk of infection and avoidable harm.
- People were not protected from the risks associated with malnutrition. One person's care plan identified they were at high risk of malnutrition. The person's nutritional intake was not quantified, and their fluid intake was not calculated on a daily basis to ensure their nutrition and fluid intake was adequate to maintain their health. Poor risk assessing meant the staff we spoke with were not aware of the person's targets for food and fluid intake.
- People were not protected from the risks associated with skin damage. One person's care plan indicated they were at high risk of skin damage. To mitigate this risk the person required repositioning. However, records did not state the frequency of the repositioning. Feedback from staff we spoke with and the records we reviewed were conflicting around the frequency of the repositioning. We reviewed the repositioning chart for the person and found variation in the times of the repositioning and some records did not state times the person had been repositioned. This placed the person at risk of further skin deterioration.
- On the day of the inspection one person disclosed they had suicidal thoughts. Staff did not have shared

understanding of the person's risks and how to support them safely. Assessments and guidance for staff about the person's mental health risks were incomplete and did not ensure the person could always be kept safe.

- When recently inspected by the food standards agency, the service had been awarded a food hygiene rating score of one out of five, which equated to major improvement required. There were no systems, records or audits in place to monitor and mitigate any identified food hygiene risks, meaning people were exposed to the risk of avoidable harm.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care which placed people at risk of harm. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

- During day two of our inspection, we saw that some of the immediate concerns had been mitigated to protect people from the risk of harm.
- Following the inspection visit, the registered provider confirmed in writing, that a full check of the environment had been completed, and changes had been made to address the risks identified during this inspection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People told us they felt safe living at the service. One person told us, "I'm safe and well-cared for."
- Staff we spoke with knew how to raise concerns if abuse occurred. A member of staff told us, "I wouldn't hesitate to report anything that was wrong."
- However, people were not consistently protected from the risk of abuse. Potential safeguarding matters had not been always been identified, escalated or investigated by relevant external agencies.
- Incidents were not appropriately reviewed, escalated and learned from. This meant that the service were unable to note trends that may be present in order to prevent comparable occurrences in the future.

#### Staffing and recruitment

- People told us there were enough staff on duty to support them. One person told us, "Plenty of staff if I need them." A relative said, "Always enough staff around."
- All the staff we spoke with told us there were enough staff to meet people's needs. Our observations confirmed that although staff were available to support people with their care needs, when required, there was not enough staff available to support people with their interests and social activities.
- Staff we spoke with, and records we reviewed showed safe recruitment checks were carried out before staff started their roles.

#### Using medicines safely

- Senior care staff took responsibility for administering medicines and we observed they did this with patience and kindness. One person said, "I get my medicines on time."
- On one occasion we observed a person was left with their medicines in a communal dining room. We saw the person did not take all their medicine as they spilt it. However, records confirmed that the medicine had been given as prescribed. We brought this to the managers attention.
- Systems to manage medicines were organised. Staff were following safe protocols for the receipt and disposal of medicines.
- Medicine competency checks were not done to ensure staff knew how to support people safely. The manager advised they would undertake immediate competency observations.



# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We found a lack of detailed capacity assessments or best interest decisions recorded in people's care plans to ensure that people had their rights upheld and protected in line with the MCA.
- When restrictions had been placed upon people, for example, the use of sensor mats, these areas had not been considered or assessed under the MCA. We also found no record of consent from people to this type of monitoring.
- One person's records showed that their relative had signed consent forms. There was no assessment in place to determine that the person had not got the capacity to consent themselves. In addition, the provider was not aware if the relative had the relevant powers to make these types of decisions on behalf of their relative.
- Staff showed poor or no awareness of the MCA and its requirements and if any people had DoLS authorisations in place and why. One staff member told us, "No-one has a DoLS at the moment." However, the manager told us, and records confirmed five people had approved DoLS in place. In addition, care plans did not contain guidance for staff to follow to ensure least restrictive practices were followed.

The registered provider was not ensuring that people's rights were protected, and this was a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Need for consent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

- People's needs were assessed prior to admission to make sure their needs could be met by the service. Some of these assessments did not include information about people's life history, culture, religion, sexual orientation and other preferences which would enable the service to deliver more personalised care.
- We found that people living with dementia had a poor quality of care and poor outcomes. There was little for people to find to enable them to engage in independent activity, a lack of sensory and tactile objects and a lack of signage to help people orient to time and place. There were no pictorial signs on doors to denote bathrooms and toilets to help people locate these independently. One relative said, "The environment is quite dull, there is nothing on the wall to keep [people] stimulated."

We recommend that the service explores the relevant guidance on how to make environments more 'dementia friendly' and how to provide meaningful stimulation to people who live with dementia.

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

- People were not always supported to eat their meal. We observed staff placed meals in front of people without explaining what their meal was. People were not always shown the meal options on offer in a way that would help them to make a choice each day. This was not supportive of people living with dementia.
- People shared mixed views about food. One person told us, "Food choices are good." Another person told us, "Food is okay, depends which cook is on."
- We found mealtimes were not a positive and pleasant experience for people. There was little attention to the dining environment. Staff were task focused and missed opportunities to interact with people.
- People told us they were not involved in the planning of meals and records we sampled confirmed this.
- Some people told us they required a diet related to their cultural, ethical and religious needs and we observed these being offered. A relative told us, "[My relative] gets Asian food a lot."

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

- We saw evidence that healthcare advice was sought with and/or on behalf of people living at the home. One person told us, "Staff will call a GP if I need medical attention."
- Staff knew what action to take in an event of a health emergency or if someone was unwell due to their health conditions. However, care plans did not always contain detail and guidance for staff to follow. For example, people living with diabetes. The manager advised us they would ensure care records were updated to ensure they contained detailed guidance for staff to follow.
- The service made available a prepared hospital transfer form to share with external agencies such as the ambulance service and hospital staff should it be necessary.

Staff support: induction, training, skills and experience

- People told us that in their opinion staff had the skills and right experience to meet their needs. One person said, "Staff are good at what they do." A relative said, "They [staff] are well trained."
- Staff told us they received regular supervision and felt supported by the manager and provider. However, the training matrix presented to us showed the current training completion level by staff at the service was under the required compliance standard set by the provider. For example, there were gaps in fresher training around medicines, MCA, Infection control and safeguarding.
- Care staff told us, and records showed that newly recruited staff undertook induction training when they first started to work for the service.

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

Respecting and promoting people's privacy, dignity and independence

- One person told us, "Staff are always trying to maintain my dignity." However, people's privacy, dignity and independence was not consistently respected and promoted.
- Whilst we observed staff promoting people's independence with tasks such as allowing people to walk freely around their home, we did not observe many opportunities for some people to take part in everyday living skills, for example, helping to set a table for lunch, if they wanted.
- People's possessions were not always respected. One relative we spoke with referenced their loved one's clothing not being valued and told us, "[Name of person] shouldn't be wearing other people's clothes, it's not right."
- We observed a staff member asking a person if they wanted to go to the toilet to have a 'pad' change. This did not promote the person's privacy or dignity.
- On two occasions people were supported and received treatment by visiting professionals within communal areas. There were no privacy screens used or available. When we discussed this with staff members, they recognised this practice did not promote people's dignity or respect their confidentiality.
- People were supported to maintain important relationships. One person told us, "My daughter can visit when they want to." A relative told us their loved one has a lot of contact from friends and said how much they enjoyed it.

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

- People told us they experienced kind and compassionate care. One person said, "Staff are considerate." A relative told us, "Staff are good and kind."
- However, we found that the providers systems did not always support the service to be fully caring. This can be demonstrated by the concerns found in other areas of this report.
- We saw some occasions where there were positive and caring interactions between staff and the people they were supporting. However, this was not consistent. Our observations throughout the day showed that interaction between staff and people seemed mainly task orientated, and when people required direct support with personal care, to move or when eating and drinking.
- Staff we spoke with understood people's needs based on their protected equality characteristics. One staff member told us, "It's a diverse community here, we respect and celebrate Christmas, Eid and Diwali."
- For some people who lived at the home, their first language was not English. They were supported by staff who reflected their diversity and culture and from our observations we saw that staff were able to communicate in the people's preferred language.

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

- One person told us, "Everything is my choice; I tend to go to bed at midnight and like to be woken up at a specific time."
- We did observe staff supporting people to make decisions. For example, people were asked what they wanted to drink.

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; Meeting people's communication needs; 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; End of life care and support

- People did not consistently receive personalised care from staff as they were not always aware of or responsive to people's individual care, emotional and support needs.
- People did not receive care that reflected their needs. There had been no consideration that younger residents' interests may differ from older residents. One younger person's individual interests had not been fully explored. The person's care records stated they enjoyed reading books with pictures in. We did not see the person participating in this activity during the days of the inspection. We observed the person with nothing to occupy them. Staff we spoke with did not know the person's interests.
- One person's care plan identified that a health professional recommended staff should support the person to reduce their weight by regular exercise. Records we reviewed showed that the person had continued to gain weight. The person was not receiving responsive person-centred care because staff told us, and records confirmed, they were not following the care plan.
- People's care plans were reviewed regularly, but these reviews were not meaningful. There was no evidence that people had been actively encouraged to be involved in discussing or reviewing their own care on a regular basis. One person told us, "I've not seen my care plan." This meant there was little evidence that people had any choice or control over their own support.

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

- The registered provider and manager were not aware of the accessible information standard.
- Information was not presented in ways that were accessible. We did not see alternative means of communication. For example, some parts of people's care plans were not written in a user-friendly way using an easy-read style with pictures and graphics. This meant people did not have easy access to information regarding the service they should expect to receive or guidance on what to do if they were dissatisfied.
- During the inspection we found that people were sat in the lounge area and, apart from the two televisions being on, there was very little for them to do. Most people in the lounge were not watching the programme as it did not interest them and were asleep. One person said, "I so enjoy the exercise man that comes in on a Monday, but Tuesday to Sunday there is nothing. I live for Mondays." Another person told us, "Activities here

are a joke."

- Relatives consistently told us they thought more should be offered to keep people occupied. One relative told us, "There is nothing to stimulate people, I've never seen a book or a magazine in the place."
- Staff were not observed providing meaningful activities with people. One member of staff said, "We do some ball games and colouring with people, not much going on though."
- People were not consistently encouraged to access and integrate with the local community with support from staff to reduce social isolation. People and staff told us there were no regular or planned trips out. A relative told us, "People are bored. We were told there would be day trips, but we haven't seen any happen."
- Care plans contained very little information to show what social activities people enjoyed. There was no guidance about how to support people, or whether people needed support, to maintain activities and interests important to them. Daily notes did not include specific details of activities people had engaged in during the day, which may also have provided important guidance for staff.
- People could not be confident their wishes during their final days and following death would be understood and followed by staff. The service had not explored people's preferences, choices, cultural or spiritual needs in relation to their end of life care. Some people who lived at the home had strong faith and religious needs and may have had specific end of life wishes. However, this had not been recorded in their plan of care.

The lack of robust processes to ensure care was personalised and able to meet people's needs effectively demonstrated a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care

Improving care quality in response to complaints or concerns

- People we spoke with on the days of the inspection knew how to raise a concern or make a complaint and staff knew how to guide people if they wished to formally complain or raise any issues. One person said, "I would go to [name of provider] straight away, I know he would listen and sort it."
- However, whilst we saw there was a formal complaints procedure this was not accessible to meet people's communication needs and this was not displayed for people and their visitors to read. This may restrict people's right to access a formal complaints process.

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has 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.

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

At the last inspection systems and arrangements were not always used to monitor and improve the quality and safety of the service. We found at this inspection the processes in place to monitor, audit and assess the quality of the service being delivered were either not in place or not effective. This meant the provider remains in breach of regulation 17.

- The provider had no systems or audits in place to assess and mitigate against the risks of harm to people in respect of their health conditions.
- The provider had no systems or audits in place to ensure that people's care plans were accurately recorded with people's current risks and give accurate guidance to staff to ensure people were supported safely and in-line with their preferred choices.
- The provider had no systems in place to show learning from accidents and incidents had taken place or how the information gathered had been used to prevent or reduce the likelihood of a reoccurrence.
- The provider had no systems and processes embedded to protect people from potential abuse. As a result, potential safeguarding concerns had not been escalated to the relevant safeguarding agencies and CQC.
- The providers had no systems or audits in place to identify and address environmental risks. These included risks and not limited to, fire safety, food safety, infection control and access to the building.
- Tools which could assist the provider to analyse the number of staff required to keep people safe were not in place. For example, a staffing tool which reviewed people's dependency.
- Although we did not identify any issues with the staff recruitment files we reviewed on the day of our inspection, the provider had no systems in place to ensure recruitment processes were robust.
- The provider had no systems or audits in place to ensure that people consented to their care.
- The providers poor oversight of staff training had failed to identify that people continued to be supported by staff who had not received up-to-date training.
- There were no systems in place to check the competency of care staff to ensure they were equipped with the skills needed and were applying their learning into practice. Medicine competencies were not undertaken in line with the services medicine policy.
- The provider had failed to identify that people did not have access to meaningful activities which reflect their interests and hobbies.
- There were no quality assurance systems in place to consider the impact of not adapting information or the environment to enable person-centred care for people.
- There was no registered manager in post. The previous registered manager had left in July 2019 and we

had not received an application to register a new manager.

- The service had not improved their last inspection rating of requires improvement and we identified continued and new breaches of regulation. We were therefore not assured that the service was consistently well-led or that the registered provider fully understood their regulatory responsibilities.

The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

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

- People told us they knew who the registered provider was and felt they were approachable. One person told us, "[name of provider] is the manager, he does listen." A relative said, "[name of acting manager] is approachable, you can ring her at any time, she always makes time for you."
- The provider and manager had not consistently ensured people received person-centred care which meant that people were not always given choice and control to ensure they received care and support in their preferred way.

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 provider and manager demonstrated that they considered the feedback we gave and shared our feedback within their service to implement changes to safety checks, audits and certain recording paperwork as an outcome.
- Following our visits, we requested and received information from the provider who told us action was being taken to mitigate the risks we had identified for people.
- There was an overt surveillance CCTV system fitted in some rooms within the home, which had become operational sometime prior to the inspection. The registered provider told us it was primarily used to enhance the security and safety of premises and property, and to protect the safety of people. The use of the system had not been updated in light of surveillance guidance. There was no signage or evidence that people's consent was sought for the use of the system
- The provider displayed their previous inspection ratings as required.
- The provider was aware of their responsibilities to be open and transparent when things went wrong under the duty of candour.

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

- One person told us they had been asked to make suggestions about the colour scheme in the reception area of the home. However, whilst people's views about the quality of care had been sought there was no system in place to evidence the feedback had been acted upon. Satisfaction surveys we reviewed were standardised and people were not given information in a format they understood.
- Staff told us they had opportunities to attend meetings with the manager to discuss the service and raise any issues. One member of staff said, "The manager is a good sincere [person] and listens to us."

Continuous learning and improving care; Working in partnership with others

- The providers oversight to drive improvement was ineffective. The quality assurance systems were limited in their effectiveness to ensure continuous improvement.
- The acting manager was new to post and there was no evidence to demonstrate how they had been supported by the registered provider. In addition, there was no evidence to demonstrate the provider had



carried out quality assurance monitoring to inform them of positive aspects of the home and identify areas for development.

- The service worked closely with the local authority quality team and health professionals as they carried out regular visits to the service.

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  People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences.  Regulation 9 (1) (3)(a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent  Consent was not always sought from people using the service.  Regulation 11 (10) (2)
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 harm due to poor risk management processes within the service.  Regulation 12 (2) (a) (h)

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The service did not maintain an accurate and complete record of people's care and treatment.</p> <p>The service failed to assess, monitor and mitigate the risks to people. The provider did not operate effective systems to monitor and assess the quality of the service.</p> <p>Regulation 17 (1) (2)</p>

**The enforcement action we took:**

We imposed conditions on the provider's registration.