Farrington Care Homes Limited

Whitway House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Whitway House Nursing Home is a residential care home providing personal and nursing care. The service can support up to 39 people. There were 30 people living in the service at the start of this inspection.

People's experience of using this service and what we found
The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. Senior staff had left and the governance of the service was under strain. As a result, the registered manager had identified that they did not feel supported to continue to manage the service effectively. The providers had been aware that this was the situation. The registered manager acknowledged that some aspects of care provision and oversight had deteriorated. Poor care practice was not identified and rectified by the provider.

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. Decision making about care practice was made by nursing staff and was not always reflected in people's care plans. The culture reflected the needs of the service rather than the needs and preferences of the people.

Risks to people's health and wellbeing were not consistently managed. Where advice had been received from health care professionals this was not always followed. Staff did not always know or follow guidance regarding people's oral care.

Care staff raised concerns with nursing staff, but these concerns were not always acted upon promptly.

Improvements were needed to ensure incidents of suspected abuse were investigated and reported to the local authority when required.

A boiler providing heating and hot water had been turned off on the advice of the fire service. Emergency plans were not robust. Portable heaters and immersion hot water heaters were used to maintain care. Staffing was increased in response to a request by the CQC that a plan be instigated to respond to the risks associated with the removal of the boiler.

Appropriate records were not maintained. Charts for monitoring people's fluid intake and how they had been helped to move to keep their skin safe were not completed accurately. Care plans were not always an accurate reflection of people's needs and were not used to ensure people received appropriate care that was appropriate to their needs and reflected their wishes.

Checks on the appropriateness of agency staff were not always recorded.

Agency staff had not all received an effective induction and staff told us they learned about people's needs from each other and took direction from nurses.
People enjoyed a range of activities but when activities staff were not able to work they were not covered, and this led to long periods of isolation for people who stayed in their rooms.

People received their medicines as prescribed although some practice was not person centred. We have made a recommendation about how medicines are given.

People enjoyed the food and the chefs were committed to ensuring high quality nutrition. However, opportunities were missed for people to benefit from their experience of meal times. We have made a recommendation about the meal time experience.

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 May 2017). At this inspection the service has deteriorated to Inadequate. Previous to the Good rating the service was rated Requires Improvement at inspections in June and November 2016.

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 Whitway House Nursing Home on our website at www.cqc.org.uk.

Why we inspected
The inspection was planned based on the previous rating. Whilst we were planning the inspection we were made aware of specific concerns related to the safety of people. A boiler providing heating and hot water had been turned off on the advice of the fire service. This boiler was later decommissioned after advice sought by HSE. This inspection did not fully examine the circumstances of these concerns. This continued to be reviewed separately to the inspection.

Enforcement
At this inspection, we have identified breaches in relation to the management of risks, protecting people from abuse, decision making not being made in line with the Mental Capacity Act 2005, a failure to provide person centred care and the overall governance of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details can found in our well led findings below.	**Inadequate**

Whitway 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an assistant inspector.

Service and service type
Whitway House Nursing Home is a '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.

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.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with nine people who used the service and three relatives about their experience of the care provided. We spoke with five care staff and six agency care staff, four nurses, two chefs and the activities

coordinator. We also spoke with the registered manager, service's nominated individual and two further representatives of the provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with social care professionals involved with the service and a member of a consultancy that had been employed by the provider.

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 10 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision and agency staff records. We also reviewed a variety of records relating to the management of the service, including policies and procedures and oversight tools.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We liaised with the local authority regarding action they had taken. We received evidence from the registered manager until 23 December 2019.

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 deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

●Institutional practices were evident in the home. Unnecessary control had been exerted over one person and personal items that were dear to them had been taken from them, at a difficult time, without a clear assessment or plan. The person was visibly distressed when describing this situation.This person also told us that a staff member told them they were the boss when telling them what to do.

●There were systems in place to protect people from harm. Staff had received training in safeguarding and understood how to report abuse. However, we found mixed evidence about the effectiveness of these systems and training.

●One person raised a concern with a member of staff about another member of staff being rough with them. This was not recorded or reported. The person was known to make this statement regularly and staff disregarded it. There had been no referral to other professionals. There was no reference to this or and risk management in the person's care plan. This put the person at risk of staff not listening to their concerns.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Appropriate safeguarding referrals had been made when suspected abuse concerns were raised by visitors to the home.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

●Where plans were in place to reduce risks, records were not always sufficient to monitor the effectiveness of these plans or ensure safe care.

●Four people were assessed as needing support to move regularly so that their skin stayed safe. Gaps in recording that meant it was not possible to determine if people had been helped to move for periods of more than ten hours. One of these people was seen to be in the same position by the inspection team over more than five hours. A staff member told us they were only repositioned slightly however this was not what was reflected in their repositioning chart.

●We spoke with the registered manager about this. They acknowledged record keeping was not sufficient to ensure people received the appropriate care and explained this had been identified as an issue with the team.

●Records were not sufficient to monitor the risks associated with dehydration. One person, who was reliant on staff for their hydration needs, had been recorded as drinking 50 mls of fluid in one day and this had not been identified as of concern or shared in a handover. The person had been put at risk of drinking an insufficient amount because records were not kept or used to monitor the care people received.

●Environmental risks were not well managed. The boiler was switched off on the advice of the fire brigade

on 15 December 2019. It was later decommissioned following advice sought by the Health and Safety Executive that determined that the flue was not safe, and the boiler was an internal boiler placed outside. Works had been commissioned to repair the boiler. Issues with the boiler had been raised with the provider over a number of years. They told us they had planned to replace the boiler in the Spring.
●A wooden ramp was left in a corridor throughout the morning of our first visit. This posed a trip hazard to people, staff and visitors to the home.
●Emergency plans were not adequate. The provider's emergency plan did not contain specific information to support staff when faced with an emergency. This meant that when the heating and hot water failed staff did not know they could turn on immersion heaters to heat water for more than 24 hours.
●Whilst the boiler was being replaced, there was no central heating in part of the building. 18 temporary heaters were available immediately, and more were provided the next day. Staff checked on people, but there was no formal plan to check heaters were used effectively or temperatures recorded to ensure people's safety.
●The folder that would be handed to emergency services personnel to assist with an evacuation was not up to date. It contained information related to people who no longer lived in the home. A person who had moved in at the start of December 2019 did not have a completed personal emergency evacuation plan. This put people and emergency services personnel at risk.

People were not protected from risks due to failures to identify and monitor relevant information and to plan for emergencies. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Some risks were appropriately assessed and managed. For example, air mattress settings were set correctly to protect people's skin.
●A person with diabetes had a person-centred care plan in place.
● Accidents and incidents were reviewed by the registered manager, to minimise the risk of re-occurrence.
● Where omissions or errors were identified the registered manager responded transparently and ensured appropriate learning amongst the staff team.

Staffing and recruitment
● Appropriate checks were made during the recruitment of staff. Recruitment files contained staff employment history and checks had been carried out to ensure they were suitable to be employed in the care sector; for example, references had been sought and gaps in employment explored. However, the home did not have information about the experience and training of agency staff present in the home during our inspection. The registered manager was able to show that this information was usually sought and rectified the issue immediately.
●The registered manager had increased night staffing levels immediately to ensure people's safety whilst the heating and hot water supply were impacted by the decommissioning of a boiler. During our visit on 17 December 2019 they instigated a plan that increased staffing at all times as they determined this was essential to meet people's needs.

Using medicines safely
● Medicines were stored securely.
● Pain management was planned and recorded effectively.
● Medicines were given as prescribed and administration systems were usually safe. However, we observed medicines being signed for before they were given to two people by a member of staff. Medicines should only be signed as given after the person has taken them, as they may choose not to take the medicine. The staff member also did not tell people what the medicines were for or encourage the person to be active in

the process. This is not safe or good practice and does not respect the person they are supporting.

We recommend you review your medicines administration processes and training to reflect the principles of medicines optimisation and person-centred care.

Preventing and controlling infection
- Staff followed appropriate infection control practices.
- Audits were undertaken to maintain and improve infection control standards in the home.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The staff team had a poor understanding of the MCA as a tool to ensure that practice is not restrictive. People had MCA assessments and best interests decisions for some care practices such as care delivery, the use of bed rails and medicines administration. However, decisions that restricted people had been made by nurses without reference to people's preferences and without applying the framework of the MCA.
- The decisions made, and the resultant care, were not always reflected in people's care plans. For example, some people were on minced diets without input from a speech and language therapist. One of these people was on minced diet because their dentures had stopped fitting. They had not seen a dentist to see if this could be resolved and nursing staff had changed their diet. This may not have been the least restrictive option.
- Nurses also made decisions about whether people stayed in bed or got up. One person asked to get up on a day when we visited. We were told they had a pressure area and needed to stay in bed. There was no reference to them being cared for in bed in their care plans. No MCA assessment had been carried out to determine if they could make this decision, however unwise it may be. If they did lack this capacity, there no best interests decision available explaining why their choice was not being respected.
- Care staff told us the nurses decided who got up. Care did not reflect the principles of least restrictive practice or enabling people to make decisions about their own care and treatment.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Appropriate applications were made under DoLS for people living in the service who lacked capacity and were subject to some restrictions. No one had DoLS authorised at the time of our visits.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
●People were at risk of not receiving appropriate oral care because care plans did not provide appropriate advice and care was not always delivered. Denture care instructions had been recorded but not added to a care plan, but staff did not know and were not following this advice.
●Two people had visibly dirty teeth when we spoke with them. One of these people told us the staff did not help them with oral care and a staff member told us they did not have time to provide this care. Another person's care delivery records indicated they had not received oral care for four days.
●During our inspection a member of care staff told us they had told a nurse they had concerns about a person's health. The nurse had not handed this information over to care staff arriving on duty and it was not referred to in hand over to care staff. They had not done basic observations to check the person's wellbeing. We raised the concern with another nurse who took observations and contacted the person's GP. The person needed medical treatment. The person had been at risk of not receiving prompt treatment.
●Two further members of care staff told us they had raised concerns regarding people's health with nurses and did not receive any feedback as to why this was not acted upon.

This was a breach of Regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●The registered manager told us they had received positive feedback from the GPs working with the home.

Supporting people to eat and drink enough to maintain a balanced diet
●People were supported to eat in the lounge and dining rooms, or in their rooms. They told us they enjoyed the food. One person said, "The food is good here."
●The chefs were committed to providing high quality food. They ensured they knew what people liked and kept up to date with good practice. We saw one chef chatting with people about their meal.
●People had varied mealtime experiences. People were not always offered the opportunity to sit up at dining table and the tables were not presented with condiments and settings to encourage their use. Where people needed support to eat staff did not always remain sat with them for the duration of their meal. One person was being supported by a member of staff who was also helping other people. Another person asked for condiments to be provided and these were only brought to them, and not offered to others.

We recommend you seek appropriate guidance about current good practice around meal time experience for people who are living with dementia.

Adapting service, design, decoration to meet people's needs
●Whitway House Nursing Home was an adapted building with challenges related to its age and layout. There was a rolling program of redecoration and maintenance, but this had not been sufficient to ensure that people's needs were met.
●Staff told us that the heating and hot water in the home had been an ongoing issue in the home with plumbers being called out numerous times due to failures of provision.
●There was not sufficient equipment to meet people's needs. Staff told us that three people needed a specialist chair they could sit in safely, but one was available. This meant only one of these people could get out of their beds at any given time. We raised this with the registered manager and they told us that the

providers were responsive and would provide additional specialist seating.

Staff support: induction, training, skills and experience

- Agency staff did not always receive an appropriate formal induction. One member of agency staff could not describe the action they should take if the fire bell sounded. They told us they had been inducted by another member of agency staff. There was no record available for this induction. We saw that staff allocation on one day of our inspection placed two agency staff working together, whilst two permanent staff worked together. This did not reflect good practice to ensure agency staff were supported to carry out their role safely.
- Staff told us they had access to training that met their needs. However, whilst training had been undertaken, the care practice in the home indicated that the training for both nurses and care staff did not reflect current practices ensuring a rights based, person centred approach to care. Staff had received training in the MCA and dignity but we saw care practice did not support the least restrictive principle or support people's dignity.
- Supervision sessions afforded staff the opportunity to address practice concerns and identify development opportunities.
- The registered manager explained that face to face training was provided to promote understanding. This reflected the needs of the staff team.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- People told us they liked the majority of the staff. One person said: "The staff are lovely."
- People were supported to maintain their appearance.
- Staff were kind when they spoke with people, but they did not always act with respect. One person was supported to eat by member of staff who walked away on a number of occasions. Staff did not always involve people in making decisions about their care
- Staff fed back that people with who are living with dementia were sometimes challenged about their perception of reality by staff. For example, a person thought they saw their parent and they were told that it was not them. This does not reflect accepted good practice and was not an approach described in people's care plans.

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

- People were not consistently involved in decisions about their care. Choices, such as where to sit, were not always offered by staff during our visit.
- Care plans did not demonstrate the people had been involved in writing or reviewing them. One person told us day to day decisions such as what to wear were sometimes made by staff.

Respecting and promoting people privacy, dignity and independence

- Some care records that a nurse was working on were kept in communal areas. This meant people who were not authorised could access them, and that people could see their records were not kept securely.
- Staff routines and preferences took priority over consistent care and people's preferences. Three members of care staff took their break at the same time. This meant people could not engage with staff during this time.
- A social care professional fed back that during a visit to the home staff entered people's rooms without knocking or explaining what they were doing.

Requires Improvement

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 deteriorated 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; 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

●Care plans were not used by the staff team to ensure people received care that reflected their needs and preferences . Care plans contained personalised information but did not always reflect people's individual circumstances or their care needs accurately. For example, a person had a history of sickness and this was not reflected in their care plan. Other people were cared for in bed to protect their skin, but this was not reflected in care plans. One person had conflicting information in their care plan as to their ability to use a call bell.
● Care plans were updated monthly, and this did not always reflect people's changing needs. Significant information from professionals or changes in a person's wellbeing were not reflected in care plans in a timely manner. For example, when people had temporary changes in medicine care plans were not reflective of this.
●Care staff could not access the care plans for people without a key held by the nurses. They told us they learned what people needed from each other and did not use the care plans. The care plans were not a meaningful and accurate accessible document that outlined the care and support needed for people to achieve the outcomes of their choosing. This meant people were at risk of not receiving care as described in their care plans and that detail of things that mattered to them may be lost.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Staff told us that decisions about care provision were made based on the guidance of the nurse on duty or agreed practice. A senior member of staff told us that they got the people up first who like to sit in the lounge so that if they run out of time people who stayed in their rooms could eat breakfast in their nightwear. This reflected a service led approach to decision making as no reference was made to the time people liked to get up or the order they preferred their morning routine to follow.
● People who remained in their rooms were at risk of social isolation. When an activities coordinator was not able to work this post was not covered. This meant people went for long periods without social interaction. Three people who stayed in their rooms did not have activities recorded for a period of six days or more in November 2019.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The activities coordinator was committed to developing the range of meaningful occupation available to people. They were working to understand what mattered to people individually. People told us they enjoyed activities. One person commented positively on the singer who had just visited. People had enjoyed visits from entertainers and local groups including the cubs and a local school.

End of life care and support

●Families were complimentary and expressed gratitude for the care their loved ones had received at the end of their lives.

●Care plans reflected people's end of life wishes and the service used a nationally recognised framework to assess their end of life care needs. However individual care plans were not updated, or temporary care plans instigated to reflect changing need at this time. One person had developed an illness and there was no care plan reflecting the specific care and support this required. Their care plan continued to read that this aspect of their wellbeing remained without concern. This failure to maintain accurate records and plan for changing needs increased the risk that people may not receive the appropriate care at this important time.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs

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.

●Care plans contained information about people's individual communication needs and staff knew how people communicated. One person was registered blind. A member of staff explained that the Royal National Institute for the Blind had been contacted for support. The person now had talking books. They told us they would use this resource again if someone needed it.

Improving care quality in response to complaints or concerns

●The service complaints policy was available in people's rooms.

●Complaints were responded to appropriately and actions taken by the registered manager to ensure the quality of the service people received was improved.

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

● Whilst most staff were caring and kind during their individual interactions with people, they worked in ways that were service, not person led. This resulted in outcomes for people where their dignity and autonomy were not respected.
●The working culture had not kept up with current practice, with the culture of the service supporting a paternalistic model of care rather than a rights based person-centred model.
●Care staff told us that decisions were made by nursing staff. Team meetings were held. There was no evidence in the minutes that these meetings were an opportunity to consider practice, rather that they were an opportunity for senior staff to share information with the team.
●People were not routinely involved in decisions about their care, or circumstances that may affect them. For example, when the providers attended the service to make decisions about actions regarding the boiler and to liaise with plumbers installing the new system. They did not identify the need to make people and their relatives aware of this situation.
● Relatives told us they felt comfortable talking to staff and the registered manager.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 had managed the service for long time. Since the last inspection experienced nurses had left the home and more recently the administrative support in the home had not been effective. The registered manager had identified that, following these changes, they did not feel they had the support they needed to manage the service effectively. The providers had been aware that this was the situation but had not re-appointed to the senior roles. The registered manager acknowledged that some aspects of care provision and oversight had deteriorated.
●Governance processes were in place but were not always effective. Daily 'walk arounds' were not taking place, so opportunities to identify and rectify issues were missed.
●The audits in place had not identified the issues with care planning, safeguarding and the MCA identified during the inspection. Some audits had not been completed since October 2019.
●The provider's quality assurance systems were not effective in identifying people's experience. The provider made visits to the home and had received reports and feedback from a consultancy employed to

support the operation of the service. However, their oversight had not been sufficient to ensure the quality of the service.

●Ongoing concerns had been raised with the provider about the boiler over a number of years. An internal document from June 2019 identified that the system was not adequate. The provider told us this work was scheduled for the Spring; however, this had not been formally planned and was undertaken without input from the registered manager or senior team. This represented a failure to plan effectively to mitigate risks to people and staff.

● Policies were not reflected in practice. The service had a record keeping policy that outlined expectations. We saw that nurses had been required to check that repositioning charts were completed at a meeting in March 2019. This action had not been effective as we found some charts had not been completed, others were completed inaccurately, and further charts were completed retrospectively.

● Staff felt part of a strong core team and most staff told us the senior team was approachable and supportive. However, they also told us there was a heavy reliance on agency staff which made working effectively difficult. Handovers with the care staff team were brief and this did not support their involvement in planning or decision making to develop team work.

●There was not an effective on call system in place to ensure appropriate oversight and decision making. For example, the registered manager had not been made aware of the attendance of the emergency services when the boiler was turned off out of office hours by a senior member of the night team. We spoke with another senior member of the night team, they were not aware of the on-call system after the initial incident had occurred. The learning that the on-call system was not effective had not resulted in information being provided to the team.

Continuous learning and improving care

● There was ineffective monitoring of the performance of the service. The failures to imbed quality assurance processes meant that the service had deteriorated rather than improved.

●The provider did not have a process in place which identified that policies and procedures were not embedded in the day to day running and culture of the service. This had an impact on the way the service was provided.

●There was not a culture of continuous improvement evident in the service. Failures in record keeping had been highlighted but nursing staff were not maintaining oversight of this and the registered manager had not succeeded in imbedding the change they had identified.

All of the above demonstrated a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others

●The registered manager and providers were responsive to concerns identified during 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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People were not receiving care to meet their assessed needs. Regulation 9 (1) (a) (b) (c) (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Care was not delivered in line with the MCA 2005. Regulation 11 (1) (2) (3) (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not protected from emerging and ongoing risks due to failures to identify and monitor relevant information. Regulation 12 (1) (2) (a) (b) (d) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.

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

Treatment of disease, disorder or injury	Allegations of abuse were not identified and responded to effectively. Regulation 13 (1) (2) (3) (4) (c)(Safeguarding Service Users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Failures of oversight had resulted in risks to people and staff not being identified or acted upon and a deterioration in people's quality of care. Recording was not accurate or complete. Regulation 17 (1) (2) (a) (b) (c) (f) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.