Kairmoore Ltd

Osborne House

Inspection report

18 Compton Avenue
Luton
Bedfordshire
LU4 9AZ

Tel: 01582967899

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

Summary of findings

Overall summary

About the service
Osborne House is a residential care home providing personal care to 15 people aged 65 and over at the time of the inspection. The service can support up to 16 people.

Osborne House is a two-storey building with communal dining, kitchen and lounge areas, a conservatory and large enclosed garden. There are wet rooms on each floor for showers that are shared. There is an office is within the building at the front of the house.

People's experience of using this service and what we found
People and relatives told us they felt safe as they had staff there to meet their needs. However, we found that people were not safe. People were being supported by staff who did not have the appropriate training, skills and knowledge to safely meet people's needs. Systems and processes to keep people safe were not in place.

The registered manager had not supported staff to develop their skills or assess their competency. This meant staff did not have the knowledge of people's health conditions and the associated risks. Staff tried to be caring and relatives told us staff acted with kindness; but staff were not empowered to use their initiative to ensure people were warm and safe.

People did not have risk assessments or care plans that showed assessment and guidance about how to meet their individual needs in-line with best practice guidance. People were at risk of harm from injury because staff used incorrect moving and handling techniques. Risk of choking had also not been addressed because the registered manager did not ensure the correct advice regarding dietary or medicine needs was in place.

The registered manager did not assess quality of care delivery, operational systems and processes. The provider did not have their own systems in place to check overall quality, systems and processes. Neither the provider nor the registered manager recognised the need for effective systems or were able to identify the concerns we highlighted during this inspection. This meant areas of concern were not identified and there were no plans for improvements.

People's relatives told us they were kept informed about care needs and overall, were happy with the care being provided. However, there was no evidence that people or their relatives were supported to have a voice about the care they received.

The environment was not suitable to meet the health conditions of some people living at the home because people's mobility needs meant they were restricted access to some areas of the environment as ramps made it unsafe for them to do so. Some areas were also in need of repair and redecoration.

People were not supported to access the community or to maintain community contacts. There were no structured or ad-hoc activities taking place and interactions with people were mainly task led. People who were actively seeking to go out during the inspection were not supported to do so as there was not enough staff. People who were observed to want company were not given it as staff were busy with tasks.

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.

We made recommendations about making access to and the design of the environment better for people living with dementia. We also made recommendations about how to support people with making decisions about their care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 06 April 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the registered manager, governance, safe manual handling, food and nutrition, records, staff training and support, insufficient pressure care management, non-reporting of falls and pressure ulcers, poorly detailed care plans and risk management and a failure to seek medical treatment for people in a timely manner. A decision was made for us to inspect and examine those risks.

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

Since our inspection visit, the provider has taken action to mitigate some of the urgent risks and is working with another provider for support to address other risks identified.

Enforcement
We have identified breaches in relation to ensuring people are supported safely, poor record keeping and care planning, failure to meet people's individual preferences and interests, lack of registered manager and provider oversight and quality assurance systems, safe administration of medicines, provision of safe environment and sufficient staffing levels along with staff training and competency.

We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Osborne 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
This inspection was carried out by one inspector and two assistant inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had resigned from their position and was not present at the time of the inspection.

Notice of inspection
This inspection was unannounced.

What we did before 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with six people who used the service and five relatives about their experience of the care provided. We spoke with seven members of staff including the provider, senior care workers, care workers, housekeeping staff and the chef.

We reviewed a range of records. This included four 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 spoke with two professionals who regularly visit 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.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● The registered manager had not sufficiently assessed risks in relation to people's health conditions and associated needs. This meant information about risks in relation to choking, moving and handling, difficult to manage behaviour and falls had not been given to staff. Staff were unable to demonstrate an understanding of the risks associated with specialist dietary and fluid needs, pressure care, risk associated with people who were living with dementia and medicines.

● There were no systems in place to identify concerns about risks and safety. The provider did not have an understanding of what should be in place to ensure safe, quality care could be delivered. This meant no plans to make necessary improvements had been identified.

● People's manual handling needs had not been assessed by a suitably qualified professional to ensure their individual needs and how these should be supported were identified. Risk assessments completed by and reviewed by the registered manager for manual handling did not give staff the guidance they needed to ensure they understood how to safely support people to move. This meant people and staff were both at risk of harm and injury due to unsafe techniques being used. Examples of this included people being encouraged to stand and walk when they were not strong enough to do so safely and dragging people across the room to the table while they remained seated in dining chairs.

● The temperature in the building fluctuated during the inspection between 14-18°C. Numerous people were complaining telling us, "It is really cold" and "It is freezing." One person who offered their hands for us to touch was very cold. There was no system in place for identifying if people felt warm enough and no one took action to look into this concern when people spoke about being cold until inspectors raised it with both staff and the provider during the visit. The provider later produced a portable heater for the lounge and for the dining room but not people's bedrooms. The home remained very cold. This meant people who, due to their age and health conditions, were susceptible to developing conditions such as hyperthermia were left being cold.

Systems and processes to safeguard people from the risk of abuse

● The registered manager had not facilitated training or developmental support about safeguarding for staff. Staff had very limited understanding of how to keep people safe, different types of abuse and how to identify them. Staff were also unclear on how to report and record concerns.

● There were no systems for monitoring incidents and accidents. The registered manager nor the provider reviewed incidents for trends and patterns or put action plans in place to make improvements and support staff to learn from mistakes.

Using medicines safely

● Medicines were not always administered safely or in accordance with recognised good practice. We

observed the medicines trolley being left unlocked and unsupervised with the keys in the door. This meant any person walking past was at risk of harm if they accessed the medicines. Staff were unaware of the potential for harm from the use of high-risk medicines such as Warfarin.
● The registered manager had not ensured staff were suitably trained and their competencies assessed in best practices for medicines management, storage and administration.
Preventing and controlling infection
● Staff followed basic hygiene in some areas such as cleaning floors and dining room tables. However, there were many areas where hygiene needed to improve. For example, one communal toilet had been left with faeces and urine in the bowl unflushed. Only the visitor's toilet had a full supply of toilet roll, hand soap and disposable hand towels.
● The registered manager had not taken action to address environmental issues that could result in a spread of infection such as poor flooring, a rusted washing machine and a hole in the wall in the laundry room. In addition to this one person had a significant crack and stain in the hand basin in their bedroom which posed a risk of infection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm and abuse. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during, and after, the inspection. They ensured stocks of hygiene equipment were replenished, arranged for staff to have manual handling training, arranged for the heating to be working properly and had employed the services of another provider to support them with identifying and acting upon required improvements.

● Despite our findings at this inspection, people still felt safe and relatives told us they felt their family members were safe. One person told us, "Oh yes I do feel safe, you see my problem before was that I kept falling down, my balance was up the pole and so it is nice to know someone is here to help me if I fall. Not as many falls now, just the occasional."

Staffing and recruitment
● People sometimes had to wait for support with food, drinks and mobility. Staff tried their best to accommodate but there were not enough staff deployed to support people without a delay.
● Recruitment procedures were not robust enough to ensure staff had the correct aptitude and skills for the role. Interview records showed staff were judged on their appearance and punctuality rather than using questions relevant to care which would have supported a fair judgement of ability and identified developmental needs. References from previous employers were in place but not verified. However, staff did each have a Disclosure and Barring Service (DBS) check.

Learning lessons when things go wrong
● There were no systems or processes in place for staff to learn from mistakes or incidents. The registered manager did not evidence how they encouraged staff to do this. Staff told us they were not aware of the opportunity to learn in this way.

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 now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff were not supported by the registered manager or provider to ensure they had the appropriate training and skills to fulfil their roles. Staff told us they did not receive an induction or training. This included key areas such as safeguarding, Mental Capacity Act and DoLS, fire safety and moving and handling.
- Staff had also not received training and support to develop a knowledge of people's specific health conditions and how they impacted individual people. This included conditions such as epilepsy, diabetes and dementia. Training was also lacking in areas such as fluid and nutrition support and infection control.
- Staff told us they did have supervision sessions approximately every three months or when they had made a mistake but they were mostly negative and did not get the opportunity to discuss concerns or development needs. Staff said they did not feel supported by the registered manager and they were not confident to approach them for support and advice.
- Staff we spoke with were unable to demonstrate a knowledge or understanding of the key areas mentioned above. This placed people at risk of harm due to being supported by staff who did not fully understand their needs and how to ensure their safety and wellbeing.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff received appropriate training and development and the support to be able to carry out their roles effectively. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during, and after, the inspection. They confirmed moving and handling training had been booked and had employed the services of another provider to support them with identifying and acting upon required improvements, whilst offering staff training and support to understand best practice guidance.

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

- People's needs were not assessed prior to moving into the service. Reviews of people's needs were also not completed with a viewed to look at individual needs, goals and progress as well as risks.
- The registered manager had produced generic care plans and risk assessments that were identical across multiple people's care records. This meant there was no personalised guidance for staff on how to deliver care in accordance with best practice or people's individual needs and preferences.

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

● People had not always been supported to have a balanced diet that met their nutritional needs. For one person the speech and language therapy team had made a record that stated they had tried to assess the person with a pureed diet but were unable to do so as there was not enough food in the service. Another person, who required thickener to be used in their fluids to minimise the risk of choking, did not have this information included within their care plan or risk assessment. The guidance for this person was handwritten in the kitchen and gave incorrect instructions. This placed the person at high risk of aspirating.
● The provider took action to ensure regular deliveries of food and we observed a delivery during our inspection visit which included a lot of fresh fruit and vegetables.
● We observed meal times to be chaotic with people and staff coming and going in a very small dining room. One person had to watch other people eating whilst waiting to be supported to eat due to there not being enough staff to support people who required help with meals.
● One person felt the food was good and said, "The food is very good, a very good cook. The portions are just right as we are sitting around all day. Vegetables we do get in one way or another, apple crumble or banana custard."
● The dining room was laid out with table cloths and vases of flowers, however some people had to ask for cutlery which had been forgotten to be laid out. The room was not big enough to enable people a choice of who to sit with and where to sit and there was no room for staff to sit next to people they were supporting to eat. This meant staff stood over people which did not support dignity or valuing people.
● Relatives were discouraged from visiting during meal times. This was a missed opportunity for social engagement and to involve relatives in the care of their family members.

Adapting service, design, decoration to meet people's needs
● People were able to decorate their bedrooms how they wanted and many people chose to put up personal photographs or pictures and books to make their room their own.
● The design of the building however, did not lend itself to enable people living with dementia or people who used mobility aids such as walking frames and wheelchairs, easy and safe access to all areas of the building. There were many ramps underneath the carpets which had both a gap and dent at the top and bottom and in some cases were steep. This meant it was unsafe for many people to access the conservatory, laundry or garden due to the risk of falls.
● There was some large and pictorial signage on toilet doors which could have helped people living with dementia to locate the toilet. However, the bathrooms were full of hoisting equipment so it was not possible to safely reach the toilet. The home did not have in place any of the types of adaptations that support people living with dementia. Adaptations such as contrasting colours to walls, seats and grab rails can help to orientate themselves and minimise risks of falls. Some areas of the home required redecoration and repair.

We recommend the provider consider current guidance on the environmental needs of people living with dementia or mobility restrictions and take action to update their practice and the environment accordingly.

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.

- People's care plans stated they did not have the mental capacity to make their own decisions in a variety of areas such as medicines, leaving the care home unsupported by staff and in relation to their care and well-being. DoLS applications had been made to the local authority and best interest processes had taken place for some people due to them requiring continuous support and supervision each day to ensure their safety and good health.
- Where best interest processes had taken place, there was involvement with people's relatives and health and social care professionals.
- Not everyone who required a mental capacity assessment had received one or an application made in relation to DoLS..
- People were not supported to identify and uphold their choices. People told us consent was not asked before tasks were completed and people's written routines were generic and not in accordance with individual interests and preferences.

We recommend the provider consider current guidance around how to support people to make decisions about their care and preferences and take action to update their practice accordingly.

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

- People were supported to access health and social care professionals as required. However, the outcomes of these appointments were not always used to inform and update care plans and risk assessments.

Inadequate

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 inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- Staff were seen to make attempts to be kind, friendly and caring towards people, however practices were not always caring as staff told us they were not empowered by the registered manager to identify areas of improvement and act on them.
- People and their relatives were positive about the care. One person told us, "For what it is I think it is very good, every place differs but in the main it is very good, the staff treat me nicely." A relative told us staff were kind and compassionate and always cared with a smile.
- Staff asked people if they were well and offered drinks. They spoke to people politely and with respect. However, staff did not consider making changes to routines and practices to meet people's individual needs. This included not recognising when people were cold and offering them blankets or heaters; or reporting the heating issue. Another example was not asking people if they would like to watch the television. Staff informed us the registered manager did not allow the television to be turned on until 6.30pm and they had failed to question this restriction.
- One person shouted and cried out they were in pain whenever staff walked away but was relaxed, calm and talkative when staff were with them. This suggested they wanted company but staff failed to recognise this need and assumed their behaviour was purely pain related and so additional interaction was not given. Staff also failed to recognise another person was re-enacting their past profession. This person was left to wander around by themselves without meaningful conversation or interaction.

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

- There was no evidence in people's files that the registered manager had involved people or their relatives, where appropriate, in reviewing their care delivery and making decisions. However, one relative did tell us they had read and signed off their family members care plan and had had an input.
- Care plans and risk assessments had not been updated for over two years except a brief sentence to state there had not been any changes.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not respected. We observed notices in communal areas which detailed personal information regarding Do Not Attempt Resuscitation (DNAR) orders, dietary requirements and laundry schedules. All of these notices were visible to other people living at the service as well as maintenance workers and visitors.
- People were inappropriately encouraged to be independent with mobility when they were not able to do this safely. In contrast, people could have been supported to be more independent in areas such as cleaning

tasks, cooking and gardening and this was not encouraged. One relative told us, "Staff didn't talk to the person when they were moving them, I thought that was inappropriate, they did not say excuse me."

● Staff showed a desire to be respectful towards people in the way they spoke to them but did not identify the breaches in confidentiality as an issue due the lack of their own training and development.

Inadequate

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 inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People did not receive care that was personalised to meet their individual needs and wishes. Staff did not know people and their interests well enough to respond to observed communication and behaviour appropriately.
- People were not supported to build on interests and hobbies. One person told us, "I spend my time sleeping I suppose, I don't have hobbies or interests now, I used to like to listen to music mostly classical. I used to be in musicals and have produced a couple too. I can't go now due to my health problem." Another person said, "The noise gets a bit much sometimes [when people are screaming or shouting]. I am friendly but not friends with other people."
- There was no attempt by staff to engage people with in-house activities of their interest. Activities were advertised on a weekly planner on the wall, one activity for each day but there was no evidence of these occurring. The provider when asked, told us they did not do those but they had plans to put an afternoon activity in place.
- One person repeatedly put on their coat and physically pulled staff to the door. Staff told us this meant the person wanted to go out, usually to McDonalds but they said they did not have enough staff on duty to be able to support this request. The staffing levels were the same each day on the rota and so additional staffing to support these types of requests to go out was not planned for and records showed they did not occur.
- People told us their families came to visit them sometimes. Other than this, people were not supported to have contact with or access to the local community.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate care delivery was in line with people's preferences. People were not supported to follow interests or have choice and control over their care needs. This placed people at risk of psychological harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during the inspection. They confirmed they will be reviewing all activities and individual interests to ensure people received suitable care that met their social, cultural and physical preferences.

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.

● People had assessments of their communication needs in place. However, these were basic and only stated if people needed the aid of glasses or hearing aids to communicate.

● There was no evidence of staff having guidance or using alternative forms of communication where people might require it such as pictorial, written, objects or observations of body language and expressions.

Improving care quality in response to complaints or concerns

● There was no formal complaints system in place but people told us they felt comfortable to tell the staff if they had a concern. One person told us, "No concerns about the care, I don't think so. I don't have family here so I would have to go to the care worker if I was worried, can't think of their name. I think I am happy to talk to them."

● Where there was record of a complaint through the local authority safeguarding processes, it had been responded to appropriately.

End of life care and support

● No end of life care was being delivered at the time of this inspection. One person had an advanced care plan in place, however this was brief and lacked detail. Other people had not been supported to consider what their wishes might be at the end of their life.

● The registered manager had not supported staff to receive end of life care training or development.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The registered manager was not present during the inspection. However, through a review of systems, processes, documents and staff interviews, it was clear the registered manager did not provide leadership appropriate to their role.
- The registered manager and the provider had not carried out any quality assurance assessment of care delivery, systems or processes. This included areas such as staff training and competency, people's health and well-being, medicines, safety and social needs. Areas for improvement had not been identified by the registered manager or the providers own systems
- Based on the evidence gathered at this inspection, the registered manager and the provider did not have an understanding of the roles and responsibilities of a registered person. Staff struggled to fully understand the responsibilities and requirements of their roles due to lack of training and support.

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

- The registered manager did not promote a person-centred approach to care delivery. The culture at the service was institutionalised, generic and task-led. Staff were not supported or empowered to achieve good outcomes for people in-line with their needs and preferences.
- People told us they were unsure of who the registered manager was. Staff told us they were not supported by the registered manager and did not feel comfortable to approach them. One relative said, "I'm not happy with what's going on there. The way the management are with the care staff. There is a bad atmosphere which is unsettling for everybody."
- The registered manager did not always record and report all incidents and accidents in a timely fashion. Records showed the registered manager was not always open and honest about what people's care needs were and how these were being managed.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the home was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during, and after, the inspection. They confirmed they had employed

the services of another provider to support with identifying and acting upon required improvements in the above areas.

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

● People told us they were not involved in meetings. Records showed that meetings with people and relatives had only occurred once in the last two years. There was no evidence of feedback being sought or surveys being sent out to people and their relatives to gain their views about care delivery. One relative told us, "We can put suggestions forward such as a newsletter to let us know about events and environmental updates, but it never happens."

● There were no records of meetings with staff. This meant that people, their relatives and staff had no formal opportunities to voice concerns or make suggestions for improvements. However, relatives told us the registered manager did contact them by telephone to keep them informed. One relative said, "[The registered manager] will contact me. Not sure what will happen when they go. Communication from the provider is not good and can be abrupt."

Continuous learning and improving care

● Staff did receive some supervision, but these were infrequent. Staff told us they did not feel able to speak up during these sessions due to concerns about how the registered manager would react.

● Staff told us they did not have the opportunity to learn from or to reflect on events. There was no evidence the registered manager encouraged staff learning or reflections with a view of improving skills, knowledge or care delivery.

Working in partnership with others

● The service worked with health care professionals and the local authority when required. The provider or registered manager did not promote or demonstrate working relationships with external professionals.

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 who use services did not have their individual needs and preferences assessed. Engagement was task led only and no plans to build on people's interests and hobbies. Regulation 9 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care and treatment. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and provider had no oversight of the service and did not understand or adhere to the requirements of registration. Management and staff did not understand the requirements of their roles. There were no governance systems for monitoring quality or for planning improvements. Regulation 17 (1) (3)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There was not enough staff deployed to safely meets peoples needs and preferences. Staff were not given the training, development and support to enable them to fulfil their roles.

Regulation 18 (1) (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were serious concerns in relation to the management of the service in areas of safety, care records, risk management, staff training and support, the environment and quality assurance systems. The registered manager had no oversight of the service and therefore no actions for improvement had been identified or acted on.

The enforcement action we took:

We have issued a Notice of Proposal against the registered manager to remove their registration.