Diomark Care Limited

Belmont Lodge Care Centre

Inspection report

392-396 Fencepiece Road
Chigwell
Essex
IG7 5DY

Tel: 02085005222

Date of inspection visit:
08 November 2019

Date of publication:
03 January 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Belmont Lodge is a care home which provides personal care and support for up to 46 older people some of whom may be living with dementia. At the time of our inspection, 33 people were being supported at the service.

Risks to people's safety were not always identified and mitigated and risk assessments did not always contain accurate information to help staff manage risk. Incidents and accidents were not managed safely to prevent a reoccurrence.

Suitable systems and processes were not in place to ensure people consistently received the care they needed and had the right to expect. Robust arrangements had not been made to safeguard people from situations in which they may be at risk of experiencing abuse.

There were insufficient numbers of skilled and competent staff to keep people safe and meet their needs. The registered manager had not based staffing levels on people's needs and the type and level of support each person required throughout the day in relation to risk. The service has several lounges, sitting areas and corridors to cover throughout the service and staff were not always deployed effectively.

People's care was not always robustly assessed and reviewed to ensure it was up to date and in line with best practice. Staff were caring but did not always have the skills and knowledge to undertake their role. The provider had not always assured themselves staff were appropriately trained, experienced or competent.

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.

Quality assurance processes were not always effective. They had not identified concerns we found during the inspection, relating to the management of behaviours

The provider had not notified CQC of all safeguarding incidents in line with legal requirements. These omissions meant CQC did not have oversight of all safeguarding allegations to make sure appropriate action had been taken.

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 (report published 29 July 2017).

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, staffing, consent to care, notifying of incidents and good governance.

Follow up
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.

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 continue to monitor information we receive about the service until we 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 safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Belmont Lodge Care Centre

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 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Belmont Lodge 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. We used all of this information to plan our inspection.

During the inspection-
We spoke with seven people who used the service and three relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager. 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 six people's care records and medication records. We looked at four staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at accident training data and quality assurance records. We reviewed all accident and Incidents in detail since January 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 now 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
• Systems were not operated effectively to safeguard people from the risk of abuse. For example, one person had assaulted people and staff throughout August and September. Whilst this had been reported to the safeguarding authority and the person had subsequently left the service. We could find no evidence following each incident that a robust protection plan had been put into place to protect other people and staff. The care plan did not provide any guidance for staff in relation to how to understand this person's behaviour or what the service was doing to protect other people.
• Safeguarding policies and procedures were not always followed when safeguarding incidents had occurred. Staff did not always recognise incidents of a safeguarding nature and not all safeguarding allegations had been referred to the appropriate authorities. For example, a staff member told us a person had alleged their money had been stolen and this had not been reported.
• One person told us, "Now I've got a gate on my door I feel safe. I had people wandering in and the original gate was too low and a [person] could climb over." Another person said, "I don't like the screaming and behaviour in the lounge. I realise they can't help it but when it's like that I'd rather be in my room."
• Accident and incidents were documented but there was little evidence the service used this information to learn from and prevent a similar accident or incident from occurring in the future.

The lack of robust systems and processes to safeguard people from abuse was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Risks to people had not always been identified and care was not always planned to keep them safe. The registered manager had not ensured people living with dementia were kept safe. Records showed two people had been involved in a recent incident at the service that was reported as a safeguarding concern. The risk assessments for both people were not sufficiently detailed to keep people safe. For both people it had been recorded in their care plan for staff to know their whereabouts, the risk assessments did not clarify what this meant or what staff needed to do to keep people safe. In one section of one of these people's care plan it recorded the person was low risk in relation to behaviour.
• Care plans did not record in enough detail how staff could keep people safe from falls. Records showed one person was having multiple falls, but the care plan did not contain enough guidance on how staff could help prevent falls. On one date the person had sustained four falls, on their care plan review recorded on the same date staff had only recorded two falls.
• One person sustained a serious injury resulting in a fracture in March 2019 however their falls risk assessment indicated they were at "low" risk of falls. In addition, their personal evacuation plan had not

been updated within the care plan.
• A risk assessment completed for a person with bed rails did not identify the risk associated with using bedrails adequately.
• Recommendations were made in both the fire risk assessment and electrician report, but we could not find any evidence these recommendations had been met. For example, a recommendation was made to replace battery operated door guard devices, but we could find no record that this had been done.
• One person was hoisted using a stand aid hoist, the person was asked by staff to hold on to the straps rather than the handles of the hoist. We immediately intervened so the person could hold the appropriate handle to remain safe.

The above issues were a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks in relation to people's care were not assessed or managed appropriately
• Personal emergency evacuation plans (PEEPs) were in place to instruct staff how to support people to leave the home safely in the event of an emergency

Staffing and recruitment
• Staffing levels, their skills , and the deployment of staff had not been appropriately considered alongside people's needs or the layout of the service.
• We checked dependency tools for three people that did not reflect the level of support supplied or required. One person was assessed as low dependency, but their care plan stated staff should always know their whereabouts.
• One person was involved in 27 incidents of assault towards other people and members of staff between August and September. However, the September 2019 dependency assessment review scored this person's behaviour as "zero" which was explained as alert and sociable and assessed them as having "low" dependency needs. This person has now left the service.
• A third person identified at risk of inappropriate behaviour and requiring close monitoring was assessed as medium. As dependency tools are used to identify appropriate staffing levels within the service we were not assured the dependency tool was effective.
• During an observation in one lounge we found people were left without call bells and no staff were visible for long periods of time.
• During the afternoon in the same lounge a new admission had a heated verbal exchange with another person, no staff were present to diffuse this situation. Fortunately, one person walked away before the argument escalated. The inspector alerted staff to this risk.
• Accident analysis carried out by the inspector indicated numerous incidents were unwitnessed or stumbled upon when staff walked past. Between June and September of this year we identified 30 unwitnessed accidents and incidents with 16 resulting in injury. We raised these concerns with the local authority following this inspection.
• Accident/Incident recording was poor with often no evidence of outcome or action taken following these accidents/Incidents. The registered manager did inform us that some action had been taken such as referral to the falls service. However, this information was not always recorded appropriately.

The provider had not ensured that there were sufficient staff to meet people's needs. This increased the risk of people's needs not being met in a timely way and 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.

Learning lessons when things go wrong
• Incidents and accidents were recorded and reviewed by the registered manager. Information recorded was limited. There was no evidence within the analysis that demonstrated themes or trends were looked at or

considered. The numbers of accidents and incidents listed on their analysis differed to the information we found. For example, in June the registered manager had recorded four falls, we identified eight, in September the registered manager had recorded three incidents of confrontation, we identified nine incidents.

Using medicines safely

• There were suitable systems in place for the storage, ordering, administering, monitoring and disposal of medicines. Storage temperatures were monitored to make sure medicines would be safe and effective.
• There was information to guide staff on when medicines prescribed 'when required' should be given. The administration of these medicines was monitored so medicines reviews could be arranged when necessary.
• Staff received medicines training and competency checks had been completed to make sure they gave medicines safely.

Preventing and controlling infection

• There were systems in place to prevent and control the risk of infection.
• The registered manager completed monthly infection control audits. However, some armchairs, hoists and specialist chairs we looked at required deep cleaning.
• Staff had completed infection control training and used personal protective equipment such as disposable aprons and gloves when supporting people with personal care.

Requires Improvement

Is the service effective?

Our findings

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

At 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.

Staff support: induction, training, skills and experience
• Most staff had completed their mandatory training. However, given the nature of the incidents we found during the inspection related to challenging behaviour very few staff were up to date with this training. Only 11 staff had received this training within the last two years.
• Information recorded on incidents was poor. For example, on one ABC chart (Used to record behaviour) the response recorded by staff including a staff member refusing to assist a person due to their behaviour and another staff member telling the same person their behaviour was wrong and the person was recorded as assisted to bed immediately. This was brought to the attention of the registered manager straight away.
• The majority of people living at the service lived with dementia and we found most staff had not received dementia training since 2015. The registered manager did tell us six staff had recently attended the virtual dementia tour, but this was not recorded on the training plan.
• Staff told us, and records demonstrated supervision meetings took place on a regular basis. However, for one staff member we found two supervision records that recorded their interactions with people that used the service was poor. These supervisions were recorded for July and September 2019. We could not find any evidence the staff members competency had been assessed or additional training had been provided.
• An effective system was not in place to observe staff practices to ensure the correct procedures were carried out, for example following incidents. Staff had received injuries following some of the incidents of challenging behaviour, we could not find any evidence these incidents were discussed with staff or their practice reflected upon following these incidents.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Staffing.

• Most staff spoke positively about their training and opportunities. One staff member told us, "If I need any training I will speak to the manager. We did the LGBT community training recently. Another staff member said, "I am doing a level three diploma at the moment here and have also developed myself outside of the work place, I reflect on my work about what I did and if I did it right."

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's 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.
• CCTV was present in communal areas of the service, whilst a small sign was displayed in the entrance there was no evidence consent from people that used the service had been obtained.
• One person's DoLS expired on 20 September 2019 and whilst a new application had been sent it was not sent until 26 September 2019. Another person's DoLS expired 04 May 2019 and a new application was not sent until 14 May 2019.
• Two people had conditions as part of their DoLS authorisations and we could find no evidence in either person's care plan these conditions had been met.
• Applications to authorise a deprivation of liberty were not always made in a timely manner. One person had a risk assessment for absconding dated 12 November 2018 which was the day of their admission. However, an application to deprive them of their liberty was not sent until 26 June 2019. This person was also not included on the registered managers overview of DoLS applications.
• A deprivation of liberty checklist was contained in each person's file; however, this did not demonstrate an accurate assessment of whether a person required an application to deprive them of their liberty.

The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Most people and relatives told us staff asked for their consent prior to delivering care. One relative told us, "They really understand my [family member] and are polite to them and always ask permission before they do anything."
• During our inspection we observed staff asking people for consent. For example, staff asked people if they wanted clothes protectors on at lunchtime.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to moving into the service, however there was no detailed evidence people's choices were taken into consideration. The pre-assessment form was mainly in a tick list format and did not contain information about how people would like to receive care and support with regards to their likes, dislikes and preferences. A dependency assessment was also completed as part of the admission process and it was difficult to tell from the assessment information how staff were able to complete this dependency assessment competently. The dependency assessments we looked at were not reflective of people's care needs as we have recorded in the safe domain.
• People's risks were not properly assessed, and their care plans lacked sufficient detail about what was required to reduce these risks.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People received support from a range of health and social care professionals in respect of their needs. For example, physiotherapy, speech and language therapy, opticians, chiropody and falls prevention.

• A physiotherapist visited people weekly and the registered manager showed us a file of information related to these visits. However, there was no information recorded on the accident analysis in relation to the advice and exercises advised by the physiotherapist and whether these were being carried out effectively by staff.

Adapting service, design, decoration to meet people's needs
• There was some signage around the home to help people navigate their way around the service independently. People were able to personalise their rooms with their belongings and photos.
• There were several communal areas where people could spend time with others.

Supporting people to eat and drink enough to maintain a balanced diet
• People were positive about the food, one person told us, "I like plain food and I'm not keen on the pies unless it's beef. They will make you something else if you don't like what they are presenting to you that could be egg and chips or omelette." Another person told us, "The food is good most of the time."
• During our observation in one dining room the food was delivered individually on a tray, it was well presented and appeared warm and tasty and indeed one person commented on how delicious the soup was. Staff spoke to people at their level when answering queries or checking on people's choices. The interactions were warm and friendly.
• The Chef served people in the other dining room, they were knowledgeable about people's food choices as they served and aware when people had made alternative choices.

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 now 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
• Throughout our inspection visit, we observed how support was delivered in communal areas of the service. We found staff prioritised completing tasks rather than positively engaging with people. During an observation in one lounge we observed a member of staff was always present during the morning and was actively engaged with one person. The staff member chatted to the person and involved them with drawing. However, interaction for other people was not sustained.
• In another lounge observation, staff just walked through this lounge and responded to people briefly prior to moving on. There was no sustained interaction for people during this observation, the television was continually playing adverts on a shopping channel and staff did not notice this.
• Staff were kind and patient when they were providing people with support. It was apparent people were comfortable with staff.
• The views of staff we spoke with were mixed in relation to the time they had to spend with people. One staff member told us, "There is enough staff mostly, but we do not get time to sit with people or do stuff." Another staff member said, "We do have enough time to spend with people. We dance and put music on."
• Most people and their relatives were positive about staff at the service. "One person told us, "The carers are definitely caring, and we can laugh about anything. I have no complaints about them. They say hello as they pass by but don't seem to have time to engage in a longer chat. They do their job and more." Another person said, "The carers are kind and helpful and I feel they care about me. I know they're told not to spend too much time chatting to us because they passed that on to me. They can't chat can they if there aren't enough staff to do the jobs." A relative told us, "Everyone is kind. They chat to me and know my name. I can share a joke with them – they are down to earth. It's more than a job to them."

Respecting and promoting people's privacy, dignity and independence
• During an observation one person came into the lounge with hands covered in faeces, whilst staff did respond straight away the staff member took the person to the toilet opposite the lounge and left the door wide open. The communication from this toilet could also be heard by people in the lounge, fortunately the registered manager walked by and shut the door. Only a short while later the same thing happened again with the door once again being left open until another staff member came along.
• One person was brought into the lounge by a staff member, the person pointed out the armchair was stained, so the staff member simply turned the cushion over. There was no attempt to provide the person with an alternative seat or take the cushion away for cleaning.
• One person told us, "They are kind and are respectful and my privacy and dignity matters to them." Another person said, "The carers are lovely. It's all nice and smooth with them. I get on well with them. They

encourage me to do everything for myself but I'm that way inclined anyway- I even clean my own toilet."

Supporting people to express their views and be involved in making decisions about their care
• People or their relatives when appropriate were involved in planning their care and the day to day support they received. Care plans were signed.
• Relatives told us staff supported their family member well and were happy with the care and support provided.

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 requires improvement. At this inspection this key question has now remained the same. 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; End of life care and support

• Care plans did not always identify how to meet people's needs in a personalised way. Where people communicated in ways that could be a danger to themselves or others the person's care record did not direct staff as to how to manage this effectively to give people choice and control.

• Whilst care plans were reviewed regularly we found staff had not always reviewed care plans effectively using all relevant information. Particularly from previous accidents or incidents.

• Between June and September 2019, we noted a significant amount of head injuries from falls or incidents, there was often no record the person had been reviewed by a health care professional following these head injuries.

• People were not fully supported to follow their hobbies and interests. There were not enough meaningful activities for people.

• During the inspection we observed an activity in the morning, there were eight people presents. A staff member was with one person attempting origami with serviettes with some difficulty as they kept unfolding. They then found some plastic towers (skittles) to play with another person but that never happened. The staff member then spoke to a person who was entering the room and said, "I think Yellow Submarine is your favourite. Should I put that on?" In fact, a different song was played. The haphazard nature of the 'session' seemed aimed at individuals. At no point during the period was there meaningful stimulation, particularly for those living with dementia.

• We had mixed views in relation to the activities on offer. Comments included, "There's not much to do but I don't know what else they can do about it", "There aren't enough of my type to talk to. I'm used to being active but it's not happening. Many things that go on are just one to one it seems. I get my nails done once a week and that's nice and then I can have a chat with [staff member]. I do get bored and I feel lonely "and, "Some residents are difficult because of their condition- I call them patients. I'm sorry to say that they get in the way and it's more comfortable away in my room."

• People were not supported to access the wider community as staff were too busy to support this. One staff member told us, "We do not take people out we do try to go to the garden but trips out are lacking. Staff are working tirelessly but there is not time."

• At our previous inspection a person at the end of their life did not have an end of life care plan. At this inspection one person at the end of their life did have a care plan that recorded their needs in relation to their end of life. However, other people did not have suitable end of life care plans in place to advise staff of their end of life wishes and preferences.

The above issues were a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's care was not always designed to ensure their needs and preferences were met

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's communication needs were not always understood. Staff did not always know how to communicate effectively with people with dementia.
• Information was available in a variety of formats to meet people's individual needs if requested. The service was complying with the requirements identified in the Accessible Information Standard.

Improving care quality in response to complaints or concerns
• There was a complaints procedure in place. The last recorded complaint was in 2018. The registered manager told us when things came up they dealt with them straight away, so minor issues were not recorded. This meant the registered manager would be unable to identify any themes or trends from these issues.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Some systems for auditing the safety and quality of the service were in place but these were not robust and had failed to identify many of the issues we found during the inspection. Audits had been completed by both the registered manager and provider, but they had not identified the concerns we found during our inspection.

• Opportunities to learn from incidents, address poor performance and improve practice had been missed. Analysis of falls and other incidents had not been conducted effectively. This meant themes and trends of incidents had not been identified to consider the prevention of risk. Not all the accidents and incidents we found were included on either the accident/incident analysis or the key performance indicators sent to the provider.

• We found the assessment, planning and delivery of people's care was not always safe or up to appropriate standards. Dependency scores calculated were inaccurate. Which meant staffing levels were not calculated accurately.

• The registered manager had not used their 'DoLS overview' effectively to ensure DoLS were re-applied for in line with expiry dates. Care plans did not contain information that conditions had been met.

• People's consent to the care they received, and any decisions made on their behalf were not always legally obtained in accordance with the Mental Capacity Act 2005.

• Staff had not received the appropriate training or competency checks on their practice to ensure they were able to provide care to meet specific needs.

• Following this inspection, the registered manager was asked to send immediate assurance of two key areas of concern, staffing, accidents and incidents. An action plan was submitted, however the actions in the plan did not alleviate concerns to a satisfactory level.

The above concerns demonstrated this is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations

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 Commission requires registered providers to report other incidents to us in a timely way. We noted from the records reviewed several accidents and incidents could have warranted a safeguarding alert. These events are also notifiable to the Commission but had not been. When incidents are not reported to the

appropriate authorities there is a risk that oversight of these incidents will be missed and where appropriate support may not be provided.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications of other incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People, relatives and staff were positive about the management team. One person told us, "I get on well with [registered manager]. [Registered manager] is a nice person with no airs and graces." A relative said, "When I saw [registered manager] today they said, 'Lovely to see you.' Then gave me a cuddle. It's so nice here. The place is well run."
• Whilst relatives meeting were being held surveys to gain feedback about the service had not been sent out in the last two years.
• Staff views were mixed, one staff member told us, "We are really lacking support, so I am thinking of leaving. Most carers feel burnt out and every time we have a meeting it is what we have not done." Another staff member said, "The manager is very nice, they talk to people and is very friendly."

Continuous learning and improving care; Working in partnership with other
• Accidents and Incidents did not prompt learning to improve care. A lack of robust auditing and managerial oversight meant the service did not pick up on concerns when they occurred meaning it could not learn or improve care for people.
• Some partnerships had been developed with health and social care professionals. More consideration is required to support people to access the local community.

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 18 Registration Regulations 2009 Notifications of other incidents The provider was failing to notify the Commission about incidents in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not always designed to ensure their needs and preferences were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The lack of robust systems and processes to safeguard people from abuse was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

Effective systems were not in place to assess, monitor and improve quality of care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure risks were assessed and effective plans implemented to mitigate these was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent notice of decision to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient staff to meet people's needs and the staff did not always have the knowledge and skills to provide to support their role.

The enforcement action we took:

Urgent conditions imposed