Extraservice Limited

Fieldgate Nursing Home

Inspection report

153 Portsmouth Road
Horndean
Waterlooville
Hampshire
PO8 9LG

Tel: 02392593352
Website: www.fieldgatenursinghome.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Fieldgate Nursing Home is a residential home providing personal and nursing care for up to 39 people aged 65 and over. At the time of the inspection the service was supporting 20 people.

People's experience of using this service and what we found
People did not always receive a service that ensured their safety.

Risks to people's health and wellbeing had not been effectively assessed, monitored or mitigated. Risks associated with the environment had not always been safely managed.

The provider had not established an effective system to ensure people were protected from the risk of abuse. Lessons had not been learnt when things went wrong.

Medicines were not always managed safely. Staff were not deployed effectively to ensure people received support in a timely way that met their needs and preferences.

The service was not well led.

There had been a lack of effective oversight of the service by the provider, caused by inconsistent management and inadequate governance processes.

The service was highly disorganised and records were not always complete. People were not always given the opportunity to feedback about their care. The lack of robust quality assurance meant people were at risk of receiving poor quality care.

When things had gone wrong, the provider had not acted in line with the requirements of the duty of candour.

The provider was aware of the need to make significant improvements in the service and had engaged the support of other partner organisations to enable this to happen. Following the inspection, we were provided with evidence that demonstrated improvements were taking place.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 18 December 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection the service had deteriorated, and the provider was in breach of multiple regulations.

Why we inspected
We received concerns in relation to the management of people's nursing care needs, how people were protected from the risk of harm and abuse and a lack of leadership at Fieldgate Nursing Home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. Please see the safe and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fieldgate Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse or harm, staffing, governance systems, being honest and open when things went wrong and reporting to CQC.

We are mindful of the impact of the 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.

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
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.

Conditions of registration are already in place at Fieldgate Nursing Home and these remain relevant. We have requested an action plan and continuous improvement plan from the provider to understand what they will do to improve the standards of quality and safety. We are regularly meeting with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Fieldgate Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
Five inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The provider had sought the support from a consultancy company in the absence of a registered manager. Two members of this company were acting as interim managers at the time of our inspection.

Notice of inspection
We gave a short period notice of the inspection because of the Covid-19 pandemic. Inspection activity started on 7 July 2020 and ended on 14 July 2020. We visited Fieldgate Nursing Home on 9 July 2020.

What we did before inspection
Before the inspection we reviewed information we had received about the service, including previous inspection reports, action plans and notifications. Notifications are information about specific important events the service is legally required to send to us. We received feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and 11 relatives about their experience of the care provided. We spoke with 19 members of staff including the provider, an interim manager, nurses, care workers and the maintenance person.

We observed the care being provided and reviewed a range of records. This included six people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 requires improvement. 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

At our previous two inspections in December 2018 and November 2019 we found risks were not always identified and managed effectively. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• At our last inspection in November 2019, required actions had not been completed following a fire risk assessment. This meant people were at increased risk of harm. At this inspection, the fire risk assessment was not made available to us which meant we were not able to determine if those actions had been completed. The maintenance person told us they had arranged for a new fire risk assessment to be carried out and would work with the provider to address any outstanding actions if they arose. Following our inspection, Hampshire Fire and Rescue Authority conducted a fire safety inspection. They identified areas that needed addressing to ensure people's safety in relation to fire management. The provider was given three months to make these improvements and told us they would do so.
• At our last inspection, personal emergency evacuation plans (PEEPs) were not always accurate. At this inspection we found six people did not have a PEEP in place. This meant these people may not be safely supported in an emergency situation. The provider told us they would ensure these were put in place.
• Risks associated with the management of legionella were not managed safely at our last inspection. At this inspection, we were not able to find a certificate that showed the water system was free from legionella and water samples had been tested. The maintenance person and provider told us they had arranged for a specialist company to undertake legionella testing but this was delayed due to Covid-19.
• Most people had bed rails fitted to their beds. The use of bedrails can present additional risks to a person's safety such as a potential increased risk of entrapment of the body or limbs. However, there were no risk assessments in place to ensure consideration of people's safety when using bed rails. Following the inspection, bed rail risk assessments were carried out.
• Prior to the inspection, a health professional told us they had sustained a scald when washing their hands. This was because there were no temperature controls fitted to the taps. On the day of our inspection site visit, we saw temperature controls were being fitted to ensure water ran from taps at a safe temperature.
• Individual risks to people had not been assessed, monitored or mitigated effectively.
• Prior to the inspection, we were told about a person who had a choking episode. A risk assessment had not

been implemented until an interim manager developed one. We were also told about another person who had climbed over their bed rails and then fallen, no action had been taken to reduce this risk until an external professional put measures in place to do so. This demonstrated staff did not understand risk management.
• People were not effectively protected from risks associated with their health conditions such as malnutrition, choking, pressure sores, falls, constipation and dehydration. For example, of the six people's care records we reviewed, four people had lost weight in the last six months. Effective risk assessments were not in place and no action had been taken to reduce the risk of malnutrition such as monitoring food intake, providing people with high calorie snacks or referring them to a dietician.
• Choking risk assessments were not in place where appropriate. For example, one person's care plan stated they sometimes fell asleep with food in their mouth and needed supervision when eating and reminding to clear their mouth. No risk assessment had been put in place and we saw this person ate their lunch unsupervised during our inspection.
• Another person's care plan stated they were at risk of constipation, but no risk assessment was in place. The monitoring of this was ineffective and we saw records that demonstrated they had not had a bowel movement for eight days.
• We saw entries on care plans, handover and daily records that some people had a sore area on their skin or were at risk of developing a pressure sore. Risk assessments were either not in place or if they were, they did not contain suitable guidance for staff to reduce the risk of skin breakdown.
• Where people required additional moving and handling equipment, risk assessments did not always detail person specific information such as sling size, type or positioning to ensure staff were aware how to use this equipment safety. Where people were identified at risk of falls, there was no guidance for staff to be able to reduce these risks.
• Although staff had an adequate understanding of people's needs, they sometimes lacked knowledge about how to safely manage individual risks to people. For example, one person had been prescribed thickened fluids to reduce their risk of choking. When we asked staff what level they thickened their fluids to, we were told of three different levels. This put the person at increased risk of choking. Another person's daily records demonstrated their mobility had declined and an assessment would be carried out for the safe use of a different mobility aid. However, when we talked to staff, most were not aware of this. This meant the person was at increased risk of being harmed when mobilising.
• People's needs were not effectively monitored or evaluated by trained staff. For example, one person lived with diabetes. Records demonstrated their blood sugars were consistently high which can cause health complications. No action had been taken about this until an external professional recognised this as an issue and put measures in place to reduce this.

The failure to assess, monitor and mitigate risks or to ensure the safety of the premises and equipment was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

• External professionals were supporting the service to ensure risks were reduced for people.
• Following the inspection, the provider and interim manager sent us an action plan detailing how they would ensure the health, safety and welfare of people. We saw improvements to risk management were being made.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse or avoidable harm.
• Prior to our inspection we received information about incidents that put people at risk of harm and abuse. For example, some people had sustained unexplained bruises, others had sustained injuries during moving and handling procedures and other people had lost a significant amount of weight.

• These incidents had only been recognised as safeguarding concerns by the interim managers and visiting professionals. Prior to this, these incidents had not been reported to the local authority or CQC as required.
• We additionally found there was not a system in place for safeguarding incidents to be appropriately recorded, reported and investigated. This put people at continued risk of harm.
• People were not always deprived of their liberty in a lawful way. We found some people were under continuous control and supervision and did not have a deprivation of liberty safeguard (DoLS) applied for where required.
• Staff did not always use the least restrictive measures when supporting people. For example, an allegation had been made that one person was being restrained during personal care. This was being investigated by the police at the time of our inspection.
• Where other people had bed rails on their beds there were no adequate records that demonstrated the principles of the Mental Capacity Act 2005 (MCA) had been followed. This meant people's human rights were compromised and people were placed at the risk of harm.

A failure to safeguard people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The interim managers had recognised staff did not have enough knowledge about safeguarding people from abuse and had arranged for safeguarding training to be delivered. Most staff had undertaken this at the time of our inspection, but this knowledge needed to be embedded and competencies checked to ensure safeguarding procedures were being followed.
• Following the inspection, the interim manager had developed and implemented a new safeguarding policy which clearly provided staff with guidance about what action to take if a they thought a person was at risk of harm or abuse.

Staffing and recruitment
● The provider did not have a systematic approach to determine the numbers or deployment of staff and range of skills required in order to meet the needs of people using the service and to keep them safe at all times.
• Out of the 11 staff members we asked about staffing levels, 10 of them told us they felt there was not enough staff, or staffing was not organised effectively. Comments included: "We need more care staff in the mornings, it's getting very stressful, we need to help people with feeding, hoisting, washing, dressing… then the bells are constantly going, with only two of us (care assistants) a floor, it's been chaos.", "There's not enough time … sometimes it feels like you need to cut yourself in half. Sometimes we don't get a break, the nurses don't help at all, they say they have too much paperwork.", "We need more staff at mealtimes, the nurses don't routinely help with mealtimes." An interim manager told us they would be introducing a dependency tool and addressing the organisation of staff to ensure enough staff were deployed effectively to meet people's needs.
• We observed that staff responded to people's needs and call bells were answered promptly, however, the delivery of care was often task orientated. Most people stayed in their bedroom all the time and although no one told us they didn't want to, we found people lacked emotional and social stimulation. Staff told us they did not have the time to interact with people. For example, one staff member told us, "There's not enough time to sit and chat with people anymore." The interim manager told us they would be recruiting activities coordinators to address the lack of social interaction.
• It was identified that not all staff had the sufficient skills or knowledge to undertake their role competently. For example, we found staff did not have a sound understanding of the Mental Capacity Act 2005 or how to apply this in their day to day work. There had been a lack of effective monitoring of people's health conditions and nurses had not taken accountability for this. Safeguarding concerns had not always been reported and acted on effectively. The training matrix that was provided to us only had training recorded on

it from May 2020 and the provider was not able to tell us what training staff had received when we asked. One staff member told us, "I would like more training, it's always been a fight to get it before now."
• The competency of staff had not been monitored and staff told us they had not had regular supervision.

The failure to ensure sufficient numbers of suitably qualified, competent staff were deployed was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, an interim manager had developed a comprehensive training schedule, competency assessments and supervisions were also planned.

Recruitment
• Recruitment processes were mostly safe.
• However, we found that one staff member did not have an appropriate reference in place. This had been applied for but not received. This meant there was a potential that staff unsuitable to work with vulnerable people were employed. The provider told us they would 'chase' these up.

Using medicines safely
• Not all aspects of medicines management were safe.
• Where people were prescribed their medicines on an 'as required' (PRN) basis such as pain relief or topical creams, the provider had not provided enough guidance for staff to know why, when or how this should be given. Some people had PRN protocols, but these lacked personalised information about the most effective way to support people with their PRN medication. For other people, no PRN protocols were in place at all. This meant people were at risk of not receiving their medicines in the most effective way.
• Some people were prescribed topical creams to alleviate skin conditions. There was not always guidance for staff about where these creams should be applied and the frequency or thickness of application. For example, one person was prescribed a cream and the direction on the medication administration record (MAR) stated to be applied 'when needed'. There was no information about why this cream may be needed or where on the persons' body to apply it. This meant people may not have their creams applied in the correct way. We additionally identified numerous gaps on topical MARs. This meant we could not be assured people were receiving their topical medicines as prescribed.
• We also saw medication administration records (MAR) had hand written details which had not been signed by the person completing these nor did they have a witness check to sign to say they were correct. This is not safe practice and could result in an error occurring with the potential to cause harm to people.
• Storage of medicines was not always safe because temperatures were not checked. Medicines may not be effective if they are not stored at the correct temperature.
• There was a lack of information about people's medicines in their care plans for staff to understand why people were prescribed their medicines or how to support people effectively with these.
• Staff had not received recent training in the management of medicines and although staff told us they assessed each other to ensure they were competent, we were not provided with records of this. This meant the provider could not be assured staff were competent to manage medicines safely.

The failure to ensure the safe and proper management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider sent us an action plan detailing the new systems they had planned to put in place to ensure the safe management of medicines.
• There were effective systems in place for ordering and disposing of medicines safely. People and relatives were positive about the support they received with medicines.

Learning lessons when things go wrong

● The provider did not have an effective system in place to monitor accidents and incidents, or to identify any patterns or trends.

• Some accidents and incidents were recorded in daily records but due to the lack of monitoring of these, they often got missed by staff in a senior position or the provider. There was no evidence any investigations had taken place, analysis of why these incidents may have occurred or that measures had been implemented to reduce the likelihood of this happening again. This meant lessons were not learnt when things went wrong.

The failure to operate effective systems to ensure incidents which placed people at risk were analysed to ensure improvements were identified and implemented was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, an interim manager implemented an effective system to monitor and investigate accidents and incidents to ensure improvements could be made.

Preventing and controlling infection

• Prior to the inspection we received concerns that the provider was not managing the impact of the Covid-19 pandemic. Support was sought and received from external professionals and they told us that effective infection control measures were then put in to place.

• During our inspection we found that information about Covid-19 was displayed at the entrance of and throughout the home. Staff demonstrated they followed this guidance. For example, we saw staff wearing personal protective equipment (PPE) appropriately.

• Staff had received training in infection control in May 2020 and demonstrated they understood how to prevent and control the spread of infection.

• The home was clean. Relatives were positive about the environment and the way staff minimised the spread of infection. One relative told us, "It is always kept lovely and clean, there are no odours at all." and another relative said, "When they are helping [Name] with personal care, they always wear gloves and aprons."

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 requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last two inspections in December 2018 and November 2019 the provider had failed to ensure that oversight was effective in improving the safety and quality of the care people received. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• Systems and processes were not operated effectively to ensure the service was assessed or monitored for quality and safety in line with requirements. This led to breaches of regulation in relation to safe care and treatment, safeguarding, staffing and good governance.
• The lack of systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk. For example, lack of care planning and risk assessments and poor management of medicines.
• The service was highly disorganised. There were several documents we could not access during the inspection. For example, the fire risk assessment, care records and policies.
• An interim manager told us policies were not fit for purpose and began putting up to date policies in place.
• An electronic care system was in use but most staff told us of the difficulties they had with using it. This meant some staff had implemented different recording systems. One staff member told us, "We're not good at paperwork, it's all over the place. We need to use one system, it's a nightmare, none of us had good training in [the electronic care planning system], it's all a muddle." Following the inspection, the electronic care planning system was discontinued, and one system was implemented.
• The care documents we reviewed were not always accurate or complete as described in the safe domain of this report.
• The service did not have a manager registered with the Care Quality Commission (CQC). Registered manager's and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of inspection, the service was being run by the provider and two interim managers.

• Staff told us the lack of stable management at Fieldgate Nursing Home impacted on how they carried out their role. For example, one staff member told us, "We've had four managers in the last 18 months, they all tell us to do things differently. We don't know if we're coming or going." Another said, "We need a stable manager and some decent nurses. I believe the carers can do their jobs but our problems are higher."
• The provider had failed to ensure staff received the appropriate training and supervision they required to support them to carry out their role and meet people's needs safely. This has been described in more detail in the safe domain of the report.

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

• Following the inspection, the provider and interim managers sent us an action plan detailing how they would improve the governance of the home. They told us of their plans to recruit a registered manager and clinical lead to provide the service with effective leadership. One of the interim managers planned to stay on and support the provider following these appointments to ensure continued oversight and compliance.
• The previous performance rating was prominently displayed in the reception area and on the providers website.

• The provider had failed to notify CQC of significant events that happened in the service as required by law. This included allegations of abuse and injuries to people. This meant CQC were not able to effectively monitor the service or ensure that appropriate action had been taken in relation to these incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

• The interim manager told us they would support the provider to submit notifications as required going forward.

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

• Person-centered care was not promoted in the service and people did not always receive high quality care. This has been detailed throughout this report.
• The service did not achieve good outcomes for people because the care was task focused and was not empowering of people. One staff member told us, "I feel in this home they have set routines where people get up and go to bed at certain times. It is institutionalised."
• There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home.
• Staff told us they did not always feel valued or listened to. Staff told us of examples where they had raised concerns to the provider about the electronic care planning system and staffing levels but felt these concerns had not been taken on board and no action had been taken.
• Equality and diversity was not promoted in the service. Staff had not received training in this area and when we spoke with staff about this, some did not understand. Three members of staff told us they felt discriminated against because of their ethnicity. An interim manager was aware of this and told us they were working to put processes in place to ensure discrimination of any kind did not happen. Equality and diversity training had also been organised.
• The culture in the service was poor and staff morale was low. One staff member told us, "I am not really happy to work at Fieldgate, the main reason is the poor management." Another staff member said, "It

(Fieldgate) used to be such a nice place to work. I used to recommend it but I wouldn't now. It's heart-breaking." A third told us, "At the moment it is a scary place to be as nobody knows what's going on."

A failure to seek and act on feedback from relevant persons and other persons on the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and the relatives we spoke with during the inspection process told us they were happy with the service provided. They felt the staff were caring and provided support in a respectful and dignified way.
• Staff demonstrated commitment to the people living in the home and told us they wanted to provide good quality care to the people living there.
• The provider and interim managers provided us with an action plan following the inspection which outlined how they would improve the culture of the service.

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
• There was not a policy in place or any effective systems to ensure the requirements of the duty of candour was met.
• When things went wrong with care or treatment, the provider had not demonstrated a candid, open and transparent approach. They had not informed the relevant people, investigated the incident or provided an apology.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, an interim manager put a duty of candour policy in place. They additionally demonstrated an open and honest approach.
• More time was needed for this to be embedded into practice.

Working in partnership with others
• Prior to our inspection, there was poor partnership working with other services or bodies. For example, when people needed support with health conditions, health professionals were not always sought to provide this. This included referrals to dieticians, speech and language therapists and the falls prevention team.
• During our inspection, we found this had improved. The provider and staff had started to seek support from other agencies to improve the quality of care people received.

Continuous learning and improving care
• The provider has a history of not achieving the required standards. This is the fourth consecutive inspection where a rating of good has not been achieved in well-led.
• Effective systems were not in place to allow continuous learning and improving care. More details can be found within the safe domain of this report.
• The provider had recognised improvements in the service were needed and following the departure of the last registered manager in April 2020, had enlisted the support of a consultancy company. Two members from the consultancy company took on the role of interim managers.
• The interim managers found all areas of service delivery needed improvement and raised concerns to CQC and the local authority. The local authority deployed teams to support the service and help them make the required improvements.
• The provider demonstrated a willingness to improve. They took all suggestions on board and told us they would "Do what it takes to make improvements for the people who live here."

• Staff in the service also told us they wanted the service to be better. External professionals were positive about staff engagement and told us staff had followed all instructions and completed any task asked of them.
• Following our inspection, we asked the provider to complete an action plan. This was completed and we could see some improvements had been made although the service had a long way to go to achieve compliance with regulation.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure to notify significant events as required.

The enforcement action we took:

We imposed conditions to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed effectively, and the failure to ensure the safe management of medicines.

The enforcement action we took:

We imposed conditions to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to safeguard people from abuse and improper treatment.

The enforcement action we took:

We imposed conditions to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to have effective systems and processes in place to assess, monitor and improve the quality and safety of the service, and the failure to maintain an accurate, complete and contemporaneous record in respect of each service user.

	The failure to seek and act on feedback from relevant persons in the carrying on of the regulated activity, for the purposes of continually evaluating and improving the service.

The enforcement action we took:

We imposed conditions to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The failure to act in an open and transparent way when things went wrong.

The enforcement action we took:

We imposed conditions to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure sufficient numbers of suitably qualified, competent staff were deployed.

The enforcement action we took:

We imposed conditions to the providers registration.