Sunshine Care Group Ltd

# The Vale Care Home

## Inspection report

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## 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
The Vale Care Home is a residential care home providing personal and nursing care to 36 people aged 65 and over at the time of the inspection. The service can support up to 40 people. The home is set over two floors with communal spaces on each level. There were also bathing and bedrooms on each floor. There was an accessible garden.

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

The service lacked provider and management oversight, audits which had been completed had not identified where actions should be taken. Some areas had not been identified as requiring audits. The provider had not ensured good oversight of the home in maintaining people's care and safety. The registered manager was not supported in their role. Staff and people's views were not always responded to, to show how improvements were being made.

The provider had not always worked with partners to maintain the environment, leaving some areas at risk of not being repaired to meet best practice or regulations.

Risk to people were not always assessed and actions taken to mitigate the impact. Measures were not in place for safe emergency evacuation.  Staff recruitment was not robust to ensure staff were safe to work with people. There were not enough numbers of staff to support people's needs.

Training was not in place for all areas to support the staff in their role. Staff supervisions were not always in place to support new starters or to review ongoing support needs. Safeguarding concerns were not always reported and people may not be protected from harm.

Infection prevention and control was not always well managed, some areas of the environment required attention to ensure it was kept clean and in good repair. Medication was not always managed safely, and some areas were not monitored effectively to ensure ongoing measures were put in place.

Care plans were not always up to date or did not contain important information about people's life choices and ongoing care. Where people had behaviours which challenged, there were no consistent care plans or guidance for staff to know how to manage a difficult situation.

We found some areas were people's dignity was compromised and this had not been recognised and audits of the recording charts had not been completed.

Staff were kind and committed to providing good care, however, felt restricted by the lack of support, training and organisation.

People enjoyed the meals and had been involved in the menu planning. Social activities were provided, and people had an opportunity to choose how to spend their day.

People's health care had been monitored and referrals had been made to the required professionals to support health conditions. Good partnerships had been established with health and social care professionals.

There had been no complaints, and relatives and representatives felt able to contact the registered manager if required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 the service under the previous provider was rated Requires Improvement (Published 23 January 2020).

This was the first inspection with the new provider registered with us on 8 October 2020. At this inspection improvements had not been made/sustained, and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about infection control and whistle blower concerns. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
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. 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.

We have identified breaches in relation to safeguarding, safety, staffing levels, training, and good governance at this inspection.

The provider responded swiftly to our concerns and has put an action plan in place to address the concerns raised and are working with us to monitor the service.

Please see the action we have told the provider to take at the end of this report.

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

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

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

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

The service was not safe.

Details are in our safe findings below.

**Inadequate**

**Is the service effective?**

The service was not 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**

# The Vale Care Home

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection was completed by two inspectors. An expert by experience completed telephone calls to family and representatives of people receiving care. 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
The Vale Care 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the local authority and reviewed information we held about the service. We used all of this information to plan our inspection.

During the inspection-
We spoke with three people who used the service. Our Expert by Experience spoke with seven relatives or representatives of people receiving care. We spoke with six members of staff including the housekeeper, nurse, care staff, deputy and registered manager.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

# Is the service safe?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate: This meant people were not safe and were at risk of avoidable harm.

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

- Risks were not always managed. We found several people with sore skin and measures had not been taken to reduce the impact or continued discomfort.
- Topical creams had been prescribed for people's skin, however there was no monitoring process in place to ensure these were being applied as required. This meant people continued to have sore skin and some areas had deteriorated further.
- Some people had behaviours which challenged, there were no individual plan to consider how these people should be supported. This meant their needs may not be met or their behaviours could escalate placing themselves and others at risk of harm.
- Risk assessments were not always in place to consider how to reduce people's risk of harm. For example, a person who had some physical needs enjoyed a cigarette, however they were not provided with a fire-retardant apron to protect them from the risk of fire. Other people were at risk of falls and measures had not been taken to consider how to reduce the risk.
- Risk assessments in relation to people's long-term health conditions were not in place. This meant should the person have a decline in their health there were no measure in place or guidance for staff to respond.
- Evacuation plans for new admissions to the service had not been completed on entry. Completed evacuation plans had not always been reviewed when changes occurred which could impact on the support the person required in an emergency. This meant should there be a need to evacuate some people may not be accounted for or others have their needs met for a safe evacuation.

The provider had failed to ensure that people were protected from the risk of harm. 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 after the inspection. Measures to ensure people received the required risk assessments and treatments were put into place.

Staffing and recruitment

- There were insufficient staff to support people's needs. We saw people had to wait for their care and this could have impacted on their dignity.
- Staff we spoke with felt there was not enough staff. One staff said, "I feel I cannot spend time with people, we are here to care but cannot get things done."
- We found the communal space was unsupervised for large periods of time. This was confirmed by staff we spoke with. During an unsupervised period one person had a fall and staff were alerted by another person

pressing the call bell.
● The provider had agreed six new admission, four people had moved into the service and two people on the day of the inspection. The staffing levels had not been reviewed or adjusted to consider the additional needs of these people. Staff we spoke with said, "A third person would make a massive difference."
●Relatives we spoke with had also identified the limited staffing numbers. One relative said, "I have seen them struggle to cope with both floors sometimes, because of having insufficient staff."
● The provider did not have a robust recruitment process. We reviewed two recruitment records and found they did not contain employment history. No risk assessments had been completed or additional supervision measures identified. This meant we could not be assured the provider had taken all the required measures to ensure staff working with people were safe to do so.

The provider had failed to ensure sufficient staff were available to support people's needs. This placed people at risk of harm. This was a breach of regulation 18(1) (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. There was an increase in staffing numbers to support people's needs.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding was not always identified. Staff had received training in safeguarding; however, we could not be assured all concerns had been raised.
● We identified some people had unexplained bruises, these had not been body mapped or reported as a concern.
● We noted other incidents between two people had not been recorded. Staff we spoke with were not aware these areas should always be reported to safeguarding.
● There were no measures in place to review any safeguards and consider where there were reoccurring situations how these could be reviewed and addressed.

The provider had failed to ensure that people were protected from the risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Infection, prevention and control was not consistently implemented to reduce the risk of infections. We found staff were not always compliant with the wearing of masks in accordance with the guidance.
● The provider had personal protective equipment stations (PPE) around the home. However, we found these were not fully stocked and this meant there was not always the require PPE at point of care.
●There was a plan of cleaning within the home, however we found the high touch point areas had not been consistently cleaned to reduce the risk of infection.
● Other areas of infection control were being managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. One relative said, "When I have visited recently, they were taking all the correct COVID-19 precautions, to keep everyone safe."
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider's infection prevention and control policy was up to date.

Using medicines safely
● Some areas of the medicines were not managed well. Protocols were not always in place for 'as required'

medicine. Some people had received their 'as required' medicine regularly, this had not been identified and reviewed to consider the appropriateness of this administration.

● Room temperature checks had been completed, however we found one omission which had not been reported. We reviewed the stock of four medicines and found one was inconsistent with the administration numbers. This meant we could not be assured of the measures in place to monitor these areas.

● People had received their medicine as prescribed and staff discussed their medicine with them when they completed the administration.

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.

This is the first inspection for this newly registered service. This key question has been rated 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
- Staff had not always received training or their competency's reviewed.
- We found staff had received training in many areas, however the competency had not been reviewed to ensure their understanding. For example, safeguarding training had not resulted in safeguarding referrals being made when required.
- When people had behaviours which challenged, staff were unsure how to deal with these and the lack of a consistent approach impacted on the situations not being resolved satisfactorily.
- New staff had not received supervision or support during their probation period. This meant any required support had not been identified and could have an impact on their role.

The provider had failed to ensure that staff were suitably trained for their role. This placed people at risk of harm. This was a breach of regulation 18 (2) (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They have increased training in several areas and providing a clearer approach to monitoring and competencies.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People who were independent were encouraged to have daily choices and we saw they spent the day in line with these. For example, the time they chose to get up or accessing the outside space.
- Some people had arrangements with family to go out and these plans were supported by staff to ensure the person was ready to leave the home with appropriate clothing and any medicines.
- Nationally recognised tools were used for monitoring nutrition and weights.

Supporting people to eat and drink enough to maintain a balanced diet
- People enjoyed the meals. We saw people had been included in the menu planning for the home.
- People had a daily choice and throughout the day we saw drinks and snacks were on offer.
- We spoke to relatives and representatives and they reflected positively about the meals. One said, "The meals are good and [Name] can request an alternative if the daily choice is not what they like."
- People's weights were monitored and when required referrals had been made to health care professionals. Any guidance provided was shared with the staff and cook to ensure these were followed.

Adapting service, design, decoration to meet people's needs

● The home was spacious and there was an accessible garden, which had a designated covered smoking area.

● People were able to personalise their space and we saw photographic memories were on display in their bedrooms.

● There was a programme of redecoration and a plan to replace the lounge carpet.

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

●People received prompt health care support. There was a weekly review with the GP to address any needs. Urgent health care needs were addressed daily to ensure a swift response to needs.

● Relatives and representatives, we spoke with felt assured by the approach to health care. One said, "When [Name] lived on their own they were very stubborn around medical treatment, but at The Vale, the staff have a good way of getting around the objections and encouraging acceptance of necessary treatment." Another said, "Staff tend to call the GP and arrange all that. But they do keep me up to date with what has happened afterwards."

● Local authority commissioners and other health care professionals we spoke with were positive about the communication they received from the registered manager.

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.

● The service worked in line with the MCA and people were not deprived of their liberty without legal authorisation.

● Staff understood the important of giving choices and we saw this during the inspection. Where people lacked the capacity to make choices, staff did this for them and considered the person's best interests and their knowledge of the person.

● Care plans contained mental capacity assessments and records of decisions made in people's best interests. People and their representatives, along with any required professional were involved in this process.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● We were not always assured people were always treated with dignity and respect.
● We reviewed the Antecedent, Behaviour Consequence (ABC) charts. These charts are used to record when behaviours occur, and the actions taken are recorded to assess how the behaviour was managed. Some concerns were raised in relation to the language used by staff when completing the ABC charts. These reflected a lack of respect and understanding in how they addressed the behaviour.
● We noted some people's rooms were untidy and communal toiletries were in two of the bathrooms. This meant there was a lack of consideration for people's personal belongings or the need to have individual toiletries to reduce the risk of infection.
● We spoke to relatives and found a mixed response. One said, "The general care is reasonable, but there has been difficulty with washing hair, etc. The staff don't seem to not have time. Some staff are very diligent and make the effort and others not so much."
● Staff reflected on the difficulties of meeting people's needs as they have had several new people and not had the time to get to know them. One staff said, "The past few weeks we have had six admissions, it all seems a bit rushed and we don't know them." Lack of information about people's needs could impact on their dignity or care requirements.

Ensuring people are well treated and supported; respecting equality and diversity
● People were supported by staff who were overall kind and caring. One relative said, "I think the staff are genuinely very caring and they always have a smile and appear happy. They are always kind to [Name]."
●We saw people were supported to receive care from external professionals. One relative said, "The staff organise getting [Name's] haircut and the chiropodist to have their feet done".
● During the inspection we observed staff interactions with people which showed kindness, patience and a caring nature. We saw relationships had been established and people enjoyed the company of staff.

Supporting people to express their views and be involved in making decisions about their care
● People were encouraged to make their own daily choices. People showed a genuine connection with staff. One relative said, "Staff are all kind, attentive and cheerful." Another said, "They are so patient, especially with some people who can be quite demanding."
● Staff knew people who had been in the home for some time and understood their needs. One relative said, "Nothing is too much trouble and [Name] can do what they want. They let them do what suits them, not just what everyone else does." Another said, "When I ring up about [Name], they always have the right

information to hand or good knowledge of how they are getting on. Or they will get back to me quickly to give me the answer." This meant people were supported to make decisions which met with their needs.

Requires Improvement

# Is the service responsive?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People's care plans were not always personalised to ensure they would meet their needs.
- Some plans in relation to behaviours which challenged were not exclusive to the individual. For example, the wording used in the behaviour plans were identical and had not recognised the individual behaviours or individual methods of support required.
- Other plans did not include changes to people's care, despite a review of some care plans taking place.
- People who were new to the service did not have detailed plans and these had not always been shared with staff. One staff said, "With the new people I don't know anything about them, I am waiting for the info to be passed on."
- Relatives and representatives were not always involved in the care planning process. One relative said, "I have never seen a Care Plan and although they tell me when things happen, they don't discuss [Name] care needs, or similar issues with me in general." This meant we could not be assured people personalised needs had been considered.
- Care plans to reflect when people were approaching the end of their life contained only limited information. This meant any personal wishes people may have were not included.

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.

- Communication methods had not been detailed in the care plans and it was unclear if AIS had been considered.
- There were no other communication methods considered to support people who maybe be unable to understand the spoken word. For example, the use of picture cards to support people when making choices.

- During COVID-19, the home did not always offer the use of other communication methods to support family contacts. One relative said, "The Care Home was given a tablet to use to communicate remotely, but the WIFI connection was not strong enough, so we can't use that to communicate and make sure people are safe when we can't visit them." This meant communication was not always promoted or family relationships supported during COVID-19.

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 were encouraged to participate in activities or things of interest to them.
● Relatives we spoke with reflected on the choices available. One said, "They really try to encourage people to get involved and they ask what sort of things they would like to do, so they can feel comfortable to get involved."
● The activities staff member involved people in decisions about day to day activities and offered group and individual sessions to suit people's needs.

Improving care quality in response to complaints or concerns
●There was a complaints policy in place, and this had been shared with relatives.
● No complaints had been received since our last inspection, however relatives we spoke with felt confident to raise any concerns and confident they would be addressed.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Continuous learning and improving care

● The service was not well managed. There was limited oversight of people's skin integrity and the measures in place were not effective. Audits of handover records and daily notes were not always completed. We identified five people who had concerns in relation to sore skin, however no action had been taken to address the concerns.
● Audits were not completed for topical cream medicine administration records. Records we reviewed shows topical creams had not been applied and this meant we could not be assured that people had received the required creams, putting them at risk of further skin breakdown.
● Audits which had been completed did not always accurately reflect people's current risks. For example, a pressure care audit completed for a person stated their wounds were improving, however a wound assessment record dated the day before the audit was completed stated the wound was deteriorating. This meant we could not be assured of the audit process identifying areas of concerns and actions or improvements being made.
● Auditing systems had not always been used to drive improvement in the quality and safety of the service provided. Audits which had been completed for some people's care plans, identified areas which required action, however there was no action plan in place or timeframe to establish when these would be completed. This meant incorrect or missing information was not available to staff to refer to for guidance.
● Accidents and incidents were not analysed effectively to inform ongoing practice. The audit in place counted the number of accidents and incidents that had taken place each month, however we found no detailed analysis had been completed to identify any trends or areas to prevent reoccurrence. We also noted not all accidents and incidents had been included in the audit, this meant a full picture of people's falls history or incidents had not been reviewed and therefore possible mitigation action put in place.
● The provider's dependency tool had not been used to reflect the required number of staff to meet people's needs. Staffing numbers had not been reviewed following the admission of six new people to the home.
● The provider had not supported the registered manager with any supervision or appraisals to identify any learning or training needs. The provider had not established any oversight of the home, in ensuring audits and improvements had been implemented to meet the regulations or standards.
● The feedback notice board in the home was empty. One relative told us "Little surveys have been sent

around now and again – paper-based surveys or questionnaires – but there is no change as a result." This meant we could not be assured feedback received had been addressed.

The lack of governance oversight by the provider meant people were placed 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 after the inspection. The provider updated the dependency tool and implemented auditing processes to review actions and improvements.

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

●The layout of the home had not been considered on how it could promote people's independence. For example, people who were more independent, mobile and active were situated upstairs meaning they could not easily access the outdoor area as the stairways had keypad entry and would require staff support.

● People's outcomes were not always met, for example in relation to skin integrity or where people had behaviours which challenged.

Working in partnership with others

● The local authority's infection, prevention and control team had identified areas which required improvement. However, the provider had not ensured these areas were addressed swiftly. Where investment was required, the provider required two quotes to be obtained before action could be taken.

● An electrical installation report in June 2021 identified areas of investment were required, this had not been resolved as only one quote had been obtained. The provider's processes meant there was a significant delay in addressing issues to make required improvements to the home and to reduce the risk of possible harm.

● The provider had a positive working relationship with partner agencies such as the local authority and relevant healthcare professionals.

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

● Statutory notifications had not always been completed when required. For example, for safeguards or serious incidents. Statutory notifications are a legal requirement of the service and should be submitted when significant events occur.

● The service displayed their previous rating as they are required to do.

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

● People and staff feedback was not always responded to shared or actioned. For example, following a staff meeting in March 2021 it was agreed by the provider an additional staff member would be added to the daily shift. However, this had not happened, and staff continued to raise concerns at the staffing levels to meet people's needs and further admissions had been agreed.

● The registered manager had a 'hands on' approach, however at times we found this impacted on their ability to carry out their role and duties as a registered manager.

The provider responded immediately after the inspection. The provider has implemented a support network for the registered manager.

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<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had not ensured their processes were robust to protect people from harm. Staff had received training but no competencies to their role to enable them to recognise different types of abuse and how to report concerns |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There was not always sufficient levels of staff to respond to people's needs. The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs. Staffing levels had not been continuously reviewed to adapt to the changing needs of people.<br>Recruitment procedures were not always in place to ensure staff were safe to work with people.<br>The provider had not ensured the staff received training at a relevant level to provide them with the skills to keep people safe at all times. |

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 |
| Treatment of disease, disorder or injury | The provider had not ensured people were protected from harm, in relation to sore skin, risk assessments and managing behaviours which challenged. Safe evacuation procedures were not in place. |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider did not have established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made. Risks had not been reviewed placing individuals and others at risk of harm. |

**The enforcement action we took:**

Warning notice