Almondsbury Care Limited

Ferns Nursing Home

Inspection report

141 St Michaels Avenue
Yeovil
Somerset
BA21 4LW

Tel: 01935433115
Website: www.almondsburycare.com

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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
Ferns Nursing Home is a nursing home providing personal and nursing care for up to 39 people. At the time of the inspection 35 people were living in the home.

People's experience of using this service and what we found
The service was not well-led and managed; there were widespread and systemic failings across the service. There was a complete lack of oversight and governance in all areas. This put people's safety at significant risk. Shortfalls were not addressed, and the provider was not identifying ways to drive improvement.

Risks to people were not fully identified and risk guidance was not followed by staff. Records used to monitor peoples' health were not always completed or reviewed when there was a deterioration in peoples' health conditions.

Risks relating to infection control were not being managed safely. COVID-19 risk assessments relating to staff, external staff, and people had not been undertaken in line with published guidance. The provider had failed to ensure external staff had received appropriate training in infection control and prevention, and testing for COVID-19.

Systems to monitor and administer medicines were not safe. Some additional information was required for medicines administered on a 'when required' basis.

People were not safeguarded from potential abuse and neglect. Incidents and accidents had not been effectively analysed and appropriate action taken to prevent reoccurrence. Notifiable incidents had not been reported to the local safeguarding authority or the CQC.

There were not enough suitably trained staff available to meet people's needs. The plans in place to cover the service in the event of staff absence did not include arrangements should the management team be absent from work. At times, agency staff had been placed in charge of shifts with no management oversight. By the second day of inspection a peripatetic manager had been appointed and was managing the service.

The provider did not follow safe recruitment procedures. Staff did not receive a sufficient induction or suitable training to enable them to be skilled and competent in their role. Staff had not received appropriate supervision and appraisals.

Checks had not been completed to ensure the environment and equipment were clean and safe. Fire risk had not been managed effectively.

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 systems in the service did not

support this practice.

The provider had failed to seek and act on feedback from people, staff and relatives. Staff described a poor culture within the service; they told us they had experienced a difficult time with little support from the provider.

There were no effective systems in place to communicate with people and relatives. This was evidenced by complaints and our conversations with some relatives.

Relatives were not able to provide us with detailed feedback as they had been unable to visit the service, we received mixed feedback about the service.

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

Rating at last inspection
The last rating for this service was Good (published December 2018).

Why we inspected
We received information of concern about infection control and prevention measures at this service. The provider had an outbreak of COVID-19. This was a targeted inspection looking at the infection control and prevention measures the provider has in place.

We inspected and found there was a concern with infection control procedures and staffing and management arrangements, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe and Well-Led.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make significant improvement. Please see the safe and well led sections of this 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 Ferns Nursing Home on our website at www.cqc.org.uk.

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 eight breaches of regulation at this inspection in relation to safe care and treatment which includes medicines, infection control and risk assessment, premises and equipment, staffing, safe recruitment, consent, safeguarding people from abuse, governance, and failure to notify.

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

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 six months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ferns 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
The inspection was carried out by two inspectors onsite (only one inspector onsite at a time), one inspector and assistant inspector remotely 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.

Ferns 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not on site during the inspection and by day two of the inspection the provider told us that the registered manager was de-registering.

Notice of inspection
The inspection was carried out on 15, 25 and 26 February 2021. The inspection was announced.

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 took this into account when we inspected the service and made the judgements in this report.

During the inspection

We reviewed a range of records. This included people's medicine records. We also reviewed records relating to the management of the service such as incident and accident records, three recruitment records, health and safety records, training records and audits. We carried out observations of infection control practice. We spoke with four staff and the peripatetic acting manager during the inspection. We were unable to speak with people due to the current COVID-19 pandemic.

After the inspection
We spoke with 10 relatives and a further five staff members via the telephone. We reviewed further records and continued to seek clarification from the service 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 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.

Preventing and controlling infection

- Risks relating to infection prevention and control were not being managed safely. We were told by senior staff that when professionals visited the service, they would be required to complete a declaration form, put on personal protective equipment (PPE), and have their temperatures taken. A COVID-19 lateral flow test (LFT) would also be offered.
- On the first day of inspection the same measures had not been applied for external staff [non care staff]. There was no risk assessment to ensure that external staff had appropriate COVID-19 infection control and prevention (IPC) training, were competent in putting on and removing PPE and were being COVID-19 tested. This put people were at risk from the potential spread of infection.
- Agency staff were being used to cover staff shifts within the service. On day one of the inspection there were no assurances in place that external and agency staff were not working in other care services. Staff told us that agency staff were not always regular to the service. This increased the risk of COVID-19 entering the home.
- On the first day of inspection the procedure for staff undertaking COVID-19 LFTs included walking through the service before they had put on their full PPE. This increased the risk of COVID-19 entering the service.
- The provider failed to review and amend their cleaning arrangements in response to the COVID-19 pandemic. Frequently touched points were not being cleaned in line with published guidance, this meant they were being cleaned daily rather than frequently. This increased the potential for the spread of infection.

- The provider failed to ensure the environment was clean and well maintained. The cleaning schedule did not include arrangements for all areas of the service. For example, there were no cleaning arrangements in place for the treatment room, bathrooms and carpets throughout the service. The treatment room was visibly unclean and there were stained carpets and unpleasant odours in some bedrooms. Cleaning staff confirmed they did not go into the treatment room, another staff member said they didn't think the service was 'clean enough' and that 'You need more than one cleaner on a shift.' Senior staff did not know how often touch points were cleaned or if the deep cleaning of bedrooms had taken place.
- There was a lack of cleaning hours across shifts to enable effective cleaning. There were no cleaning staff in attendance on a Sunday, or after 2pm on most days.
- Staff had received infection control training regularly, however they had not received any specific COVID-19 infection control and prevention training, to supplement their knowledge during the current pandemic
- All of the above instances increased the risk of the spread of infection throughout the service.

Using medicines safely

- Medicines were not being managed safely. People did not always receive their medicines when required.

● Some people were prescribed medicines on a 'when required' basis (PRN) for example pain relief and laxatives. We found these medicines were not being given when required.

● There was some guidance on the medicines administration records (MARs) on how to give PRN medicines, however there were no individualised plans in place. Individualised plans give staff guidance on the signs to look out for the person that requires the medicines, what the medicines are for and contraindications with other medicines.
● Where people refused their medicines, there was not always clear guidance for staff about what action they should take. We also found that staff were not always following guidance that was in place.
● Some people were prescribed creams and ointments to be applied to their skin. There were charts in place for staff to record when the cream was applied. We found gaps in the charts we reviewed, which meant there was no evidence these were being applied by staff as required.
● Although allergies were recorded on the front sheet of the MAR folder, they were not recorded on the MAR for two people.
● There were members of staff administering medicines who had not received medicines training or had recent medicine competency checks. This was unsafe practice and put people at risk of receiving their medicines incorrectly.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;
● Risks to people were identified and there were plans in place to mitigate the risks. However, staff had not followed these plans, and records used to monitor peoples' health conditions had not been analysed and followed up appropriately.
● Health advice had not been sought when records indicated that people's skin integrity, bowel continence, weight management and hydration were at risk, as well as risks relating to insulin monitoring. For example, it was repeatedly mentioned in staff meeting minutes from September to November 2020 that people were not receiving adequate fluids. In one record it stated that people's blood pressure had lowered due to dehydration; this had been noted by nurses. There was no follow up noted to this or further minutes after November 2020. Furthermore, a member of staff said that whilst agency staff were being used fluid and supplement rounds were being missed.
● Weight management records showed that during 2020 the majority of people at the service were consistently losing weight, actions to improve on this had not been undertaken and records had not been made consistently.
● Health professionals who required input from the service whilst reviewing risk and assessing a person's needs were not provided with the information in the absence of the registered manager.
● Peoples' COVID-19 risk assessments were generic and not based on their individual needs. This did not provide assurance that people's individual needs and risks in relation to COVID-19 were being met.
● A COVID-19 policy being used by the service stated that individual COVID-19 risk assessments for staff should be completed. This had not taken place for any staff, including those that refused to take the COVID-19 vaccine, as well as those who were pregnant or returning from maternity leave. This meant the provider could not act to mitigate the associated risk. Furthermore the policy being used did not follow government guidance relating to safe care in care homes.
● Care-plans did not always contain sufficiently detailed guidance for staff about how they could mitigate risk. For example, one person had assessed mental health needs. Their care plan stated that to avoid the risk of upsetting them, staff should persuade and negotiate with the person. There was no further guidance about how this should be undertaken, or the risks involved. There had been incidences where the person's behaviour had escalated, however this had not always been recorded and therefore no action was taken to mitigate further risk.
● People's pre- admission risk assessments did not fully consider risks around their compatibility with

others residing within the service, or the risks they may pose to other people, staff, and visitors to the service.

● People were at risk of avoidable harm. There was no analysis of incidents and accidents and no falls management in place to fully identify potential causes or triggers for incidents. The provider had not ensured appropriate measures were in place to reduce the associated risks to prevent recurrence.

People were not safe because the provider was not assessing, managing and mitigating risks to people effectively, including those relating to infection prevention and control, and medicine management. 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 failed to ensure fire safety measures were implemented in the service. A fire risk assessment (FRA) dated April 2019 identified actions requiring completion within a three or six month time frame according to seriousness and risk. These actions were still not completed at the time of our inspection in February 2021.
● The service's Fire policy placed responsibility on the registered manager to ensure the FRA actions were completed. However, all named sections of the policy for delegated responsibilities were blank and the provider had not checked that the FRA was complete.
● The service environment and equipment were not adequately maintained. Records of health and safety and environmental checks were not up to date or actioned when issues were identified.
● Checks of equipment had not taken place within service dates. Wheelchair equipment had not been checked or serviced. Legionella certification and checks had not been completed.
● Water outlet temperatures had not been checked and bath temperatures were not recorded.
● Uncovered hot water pipes had not been lagged or boxed in.
● COSHH checks were incomplete and the hazardous chemicals inventory was not in place or up to date.
The failure to ensure the environment and equipment were safe was a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we contacted the local fire service about our concerns around the Fire Risk Assessment.

● On the second day of the inspection we could see that improvements had been made to the environment to facilitate safe infection control practices. The provider had also produced a risk assessment for external staff. However, there were no assurances around COVID-19 IPC training for external staff, or that external staff were not working in other services.
● During the inspection we saw that aside from the instances described above, staff had access to PPE and were observed using good PPE practices and social distancing.
● People and staff were tested for COVID-19 as per the current government guidelines. However, the procedures for obtaining consent for people were not in line with legislation. There is more about this in the well-led section of this report.
● There was a visiting policy in place, although the home was currently closed to visitors. Most relatives said they felt their relative was safe but could not answer fully as they had been unable to visit.

Systems and processes to safeguard people from the risk of abuse;
● People were not always protected from the potential risk of abuse. The provider failed to identify that unexplained bruising could indicate abuse. This meant the provider did not investigate the cause of unexplained bruising and failed to alert the local safeguarding team when unexplained bruising occurred.
● When people experienced avoidable injuries, the provider failed to recognise that this may indicate a

potential safeguarding concern. This meant they failed to contact the local authority safeguarding team in line with legislation.
● There was no oversight of peoples' safeguarding in the service.
The failure to safeguard people by not reporting potential abuse, amounted to 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.

● Following the inspection, we raised three safeguarding alerts with the local authority relating to people's care. On reviewing incident and accident records sent to us electronically we raised further safeguarding alerts. The provider had not recognised the need to raise these alerts.

Staffing and recruitment
● There were not enough suitably qualified and experienced staff to meet people's needs. The provider did not use a dependency assessment tool or have any system in place to ensure staff deployment was safe and met people's needs.
●There was a lack of staff in all areas across the service. This included nurses, care staff, activities and cleaning staff. Rotas demonstrated that after 4pm there were agency nurses leading shifts at the service and throughout the weekends. These staff were not always familiar with the service and had not always completed an induction. Some care staff shifts were also covered by agency staff. Staff said, "Mornings are always the issue because the mornings we do breakfast and then start personal care and sometimes you don't think you have enough time to do personal care and help others. We do the best we can." and, "We need to have agency every day. sometimes I'm working [Shift pattern]. As far as I know we don't have enough permanent staff."
● There were no activities staff in place to support peoples' emotional wellbeing. Relatives said, "[Person's name] did complain to me about all [the] time spent in bed and not mixing with anybody." "Residents appeared to have been shut in their rooms since December and they were only released last week." "There does not appear to be any activities for the residents, as that would mean that they would have to leave their room." The provider had not worked to ensure people had access to activities in their bedrooms.
● Staff had not received adequate training in key areas such as medicines, and safeguarding. This put people at risk as staff did not always have the skills and competency to deliver care safely. Staff training compliance was under 50% for many staff and at 0% for some key staff delivering care. Staff told us they had not completed key areas of training such as safeguarding and medicines.
● Staff had not received any specialist training for example in how to manage behaviours which challenge. Staff described occasions where they had been unable to placate people who were upset and had instead continued working in a manner that further upset people. The lack of training meant staff did not recognise these as poor outcomes for people.
● Staff had not received the appropriate level of support through supervisions, annual appraisals or competency checks on their work practice.
● The provider had failed to initiate return to work or capability procedures for staff when they met the thresholds for excessive sickness or poor performance such as poor record keeping. Staff told us this was frustrating for staff who did their job well.
● Relatives we spoke with were not confident that all staff were suitably skilled and qualified to deliver good care. Comments from relatives included, "The evidence of staff skills and knowledge is variable. Some are good but the majority are poorly trained," and "I think they could be better trained for the job." "I do have concerns about the quality of care. I don't think they really know what they are doing."

The provider had failed to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff to meet the needs of people. There was an additional failure to ensure that staff were

supported in their roles through regular supervision sessions and competency checks. This amounted to a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to establish and operate a system that ensured suitable staff were employed. Where staff have worked previously in health and social care, evidence of satisfactory conduct is required. However, two of the staff files we reviewed had references from colleagues rather than the staff members' previous managers or the provider. This meant the provider was not working in line with legislation and could not be assured they had employed people with previous good conduct.
● The provider failed to ensure they explored gaps in employment for one staff member employed and working with people. Having unexplored gaps in employment could impact on a staff member's suitability to work with vulnerable adults. The acting manager told us they would address this.

The failure to ensure there were robust recruitment procedures amounted to a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 people were not safe and were at risk of avoidable harm.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● In the weeks leading up to the inspection there had been no onsite manager or provider level oversight in the absence of the registered manager, clinical lead and office staff in the home. The responsibilities of these roles had fallen on staff left in charge who had not worked in these roles previously and lacked the required skills and qualifications to carry out those roles. In addition, agency staff had been left in charge of the service with no additional support from the provider. This had added to failures to ensure the quality of care standards were met.
● Although there was a COVID-19 contingency plan in place, this did not cover the arrangements for management cover should the management team be absent from the service. The business continuity plan was out of date as were some of the service policies.
● For at least six months prior to the inspection there had been no provider governance procedures in place to mitigate risks to people and identify and rectify shortfalls in the quality of the service.
● Service level audits had not been completed as required and those that had been were a tick box form. Any actions identified did not have a clear action plan, checks were not made on whether actions had been completed. For example, staff medicine competencies had been repeatedly raised as requiring completion since at least September 2020 and had not been undertaken.
● Care plan audits had not been completed. This meant people's care plans were not up to date and may not have reflected their current needs.
● Records had not been robustly checked or analysed to ensure that when people's health related needs were not being met, action was taken promptly, and in line with people's care plans to prevent further deterioration to their health.
● The provider failed to implement checks to identify people who did not have appropriate best interest decisions in place. This meant the provider could not be assured that staff supported people in the least restrictive way possible and in their best interests.
● Medicine audits failed to identify shortfalls found at this inspection, such as a lack of guidance recorded in PRN protocols.
● Audits had failed to identify the lack of follow up to the 2019 fire risk assessment.
● Infection control audits had not been undertaken with specific reference to the COVID-19 pandemic. The last infection control audit had been undertaken by a cleaner in January 2021 and had not been signed off by the provider or any manager. There had been no check on issues raised such as a lack of Legionella checks.

● There were no oversight checks of the cleanliness of the service; the last environmental audit dated January 2021 had been completed by a cleaning staff member rather than a manager or the provider. There was no provider or management level oversight of cleanliness in the service. The audit was not meaningful as it stated that actions were complete, where they clearly were not. We saw issues not identified, including clinical bins not being cleared daily due to no cleaners being on site on a Sunday.
● All staff meeting minutes indicated that people were not receiving food and fluids effectively due to staff not assisting people. There was no provider oversight of this or action plan to ensure people's needs were met.
● Weight management audits in September, October and November 2020 showed that people were continuously losing weight. There were no clear action plans for improvement or individual weights recorded in an audit so that an overview could be developed to monitor weight loss. There were no further audits after November 2020. One relative told us "[Person] has deteriorated a lot since November. In fact [person] has lost [X] kilograms."
● The provider had not sought the views of people, relatives, staff or other professionals. There had been some conversations recorded with eight people and nine staff over the course of 2020 however these were themed conversations and did not cover the overall quality of service. The issues raised by people and staff were a lack of staff. People had made comments that their call bells were not attended to as quickly as they would like. There were no resulting action plans or call bell audits to ensure the provider could oversee any improvement.
● There were no residents or relatives' meetings taking place due to the current COVID-19 pandemic, however the provider had not sought any alternative means of gaining feedback.
● Relatives told us communication and feedback requests had been lacking from the service and when they tried to make contact with the service it was difficult to get information. Relatives said; "I ring them from time to time to see how [Person] is…Sometimes it is difficult to get an answer when you ring." "I haven't been asked to fill in a survey to see what I think of the care and the home," and "There are never any updates." "The phone rings and rings when you try and get in touch with the office. One week the [Relative call] appointment was cancelled without any notice."
● Service level audits carried out during the week of inspection indicated that the service was failing in key areas already described in this report.

The failure to ensure the mitigation of risk to people and the quality of service provision through effective governance was a breach of Regulation 17 (Good governance) of the Care Quality Commission (Registration) Regulations 2009

● Consent to COVID-19 testing had not been sought in line with Mental Capacity Act guidance and legislation for all people. For example, people's relatives had given consent on people's behalf for testing over the telephone. These relatives did not however have power of attorney, and the legal right to provide consent. For some people there was a best interest decision and/or a mental capacity assessment. However, the full process had not been followed.
● Consent to COVID-19 vaccination had not been sought in line with Mental Capacity Act guidance and legislation for all people. For example, consent for one person had been signed off by a member of staff despite the person having mental capacity. There was no explanation for this.

The failure to ensure that peoples' rights were upheld in line with Mental Capacity Act legislation was a breach of Regulation 11 (Consent) of the Care Quality Commission (Registration) Regulations 2009

All registered services must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. We use this information to monitor the service and to check how

events have been managed.
● Notifications were not always submitted as required. Incidents which fell under serious injury and safeguarding concerns had not been notified to the Commission.

The failure to submit notifications was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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
● We were not assured that the provider had acted with a duty of candour due to the number of safeguarding events, incidents and complaints we found that had not been effectively recorded or notified to us.
● We were also not assured as staff had not properly explained to people why they were wearing PPE. Staff had told people untruthfully that they were protecting [people] from staff 'colds. No work had been carried out with people to help them understand there was a pandemic.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● The systems in place and the way the service was led and managed did not ensure a safe, reliable service which ensured good outcomes for people.
● There was poor leadership and culture within the service. Some staff told us they were aware of divides amongst staff and tried to stay away from conflict whilst others openly described other staff in poor terms.
● Staff meeting minutes from 2020 show a lack of respect for leadership, 'bickering' 'griping' using 'derogatory language' and stating, 'It's not my job' were common themes across the meetings. There were no staff meeting minutes after November 2020.
● When staff completed behavioural charts for people they did so ineffectively and on occasion wrote about people in a manner that was derogatory to them. This had not been identified and prevented by the nurses in charge or via provider oversight.

Continuous learning and improving care; Working in partnership with others
● We were not assured of any continuous learning to improve care due to poor levels of compliance in staff training, a lack of leadership, and poor outcomes for people.
● The service worked in partnership with local health professionals, however it was clear from records that the staff did not always follow the guidance provided.

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 had failed to ensure statutory notifications were submitted for notifiable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure peoples' rights were upheld in line with Mental Capacity Act legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the mitigation of risk to people and the quality of service provision through effective governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure robust recruitment procedures for staff were followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were

sufficient suitably qualified and experienced staff and that staff had appropriate training and supervision.

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 provider had failed to assess, manage and mitigate risks to people effectively, including those relating to infection prevention and control, and medicine management.

The enforcement action we took:

Warning notice

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 provider failed to safeguard people by not reporting potential abuse.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the environment and equipment were safe.

The enforcement action we took:

Warning notice