Albert Residential Home

Albert Residential Home

Inspection report

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Date of inspection visit:
27 September 2019
02 October 2019

Date of publication:
13 December 2019

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
Albert Residential Home is a care home providing personal and nursing care to three people living with mental health needs and physical disability living in one adapted building. There were three people using the service at the time of our inspection.

People's experience of using this service and what we found
People were at risk of harm as there were unsafe arrangements for dealing with emergencies in relation to fire safety management. People's dependency assessments were not carried out to determine staffing levels and to deploy adequate staff for day and night shift. People received their medicines but were not managed safely. People were not protected against the risk of infection. There was no system and process to prevent reoccurrences of incidents and accidents. People were not supported to access information in a way they understood. People were not cared effectively. People were not afforded meaningful activities to keep them simulated and access the community. The provider had a system to manage complaints. However, we noted the registered manager had not responded to the complainant in a professional way.

There was a registered manager in post, however, they did not understand their role and responsibility in line with the Duty of Candour. People did not receive a service that was well-led. There were systematic and widespread failings of the monitoring and oversight of the service. The provider had not notified CQC about a safeguarding investigation.

We have made two recommendations about the complaints management and completing person centred care plans.

Pre-admission assessments of people's needs were in place. Staff were trained to ensure they had the appropriate knowledge and skills to meet people's needs. People's nutritional needs were met. People had access to local healthcare professionals including a GP surgery, district nurses, speech and language therapist and dietician.

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. Staff we spoke with understood the importance of gaining people's consent before they supported them

People told us they were happy with the service and staff were kind and treated them with respect. People were involved in the initial assessment and planning of their care. People were treated with dignity, their privacy was respected, and were supported to maintain their independence.

People had care plans which described their likes, dislikes, interests, family and friends, communication, healthcare needs. People's end-of-life preferences had been discussed with them, and care plans developed

to ensure their preferences in this area were met

The provider sought people's views through the use of satisfaction surveys and worked in partnership with a range of professionals and acted on their advice.

Rating at last inspection: The last rating for this service was good (published 26 June 2017).

Why we inspected: This was a planned inspection based on the previous rating.

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

Enforcement
We have identified breaches in relation to fire safety management, adequate numbers of e staff, management of medicines, risk of cross contamination, to prevent reoccurrences of incidents and accidents, access to information in a way people understood, a meaningful activity to keep people simulated and access the community, notification to CQC, and there were systematic and widespread failings of the monitoring and oversight of the service found at this inspection.

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 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

Albert Residential 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
This service was inspected by one inspector on the first day. Two inspectors returned to the service on the second day, to complete the inspection.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 27 September 2019 and ended on 2 October 2019.

What we did before the inspection
We looked at all the information we had about the service. This included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used this information to plan our inspection.

During the inspection

During the inspection, we spoke with two people to seek their views about the service. We also spoke with one member of staff, and the registered manager. We reviewed a range of records. This included two people's care plans, risk assessments and three medicines records. We reviewed four staff files in relation to recruitment, induction, training and supervision. We also reviewed records relating to the management of the service which included policies and procedures, health and safety checks, accidents and incidents, surveys, and various quality assurance reports.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at fire safety medicines, staffing recruitment checks sent by the provider and contacted the commissioners and safeguarding team for their feedback.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● People were at risk of harm as there were unsafe arrangements for dealing with emergencies. During the two-day inspection we identified six fire doors on the ground floor had been wedged open by either rubber door stops or ornaments. We also identified the fire door leading into the lounge had been removed from its hinges.

● We raised our concerns with the registered manager who told us, "It wasn't a problem for the fire officer, but I can put the door back on." The registered manager also informed us they were looking at potentially purchasing fire door guards. Fire door guards are door stoppers that allow the fire door to remain open, however will automatically close on the fire alarm sounding.

● People were placed at significant risk of harm as the provider did not take reasonable steps in relation to fire safety management. On the first day of the inspection, we identified Personal Emergency Evacuation Plans (PEEPs) were in place, however these were not personalised and did not take into consideration people's specific mobility or medical needs and equipment, to support them to exit the building safely in the event of an emergency. There were no records to indicate fire drills and evacuations had been carried out in the last 12 months.

● We raised our concerns with the registered manager who told us, they would complete person centred PEEPs as a matter of urgency. On 01/10/2019, the registered manager wrote to us saying they have updated the PEEP to reflect they were personalised. However, on the second day (02/10/2019) of the inspection we identified, and the registered manager confirmed, the PEEPs had not been updated. This meant despite assurance from the registered manager people were still not being protected from risks that can arise if there are inadequate fire safety arrangements.

● One person at the service used an oxygen machine, however the risk assessment carried out by the registered manager, did not take the fire hazard associated with the oxygen machine, nor give guidance for staff to mitigate the risk. We also identified the oxygen tube trailed along the floor and was a trip hazard to both the person and staff. We raised our concerns with the registered manager who failed to recognise this was a trip hazard and told us, "It's not a trip hazard."

● The registered manager failed to carry out audits relating to fire safety and safety of the environment. During the inspection due, to concerns we identified, we contacted the fire authority to report our findings.

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

● Notwithstanding the above, records confirmed the registered manager completed risk assessments for

people which had guidance on how to reduce risks. These included risk management plans around falls, eating and drinking, and continence management.
● External agencies, where necessary, carried out safety checks on the emergency lighting and the safety of gas appliances.

Staffing and recruitment
● People did not receive care and support from adequate numbers of suitable staff to keep them safe. The provider did not devise rotas indicating who was working on what shift. Medicines administration records indicated the registered manager had been working seven days a week, day and night, with no indication of any breaks from work. We raised our concerns with the registered manager who further confirmed and said, "I don't take leave and work on all days." "We cover the shifts between the three of us." We found no evidence to support the registered manager's statement. This meant putting people at risk and also possibly not meeting employment laws.
● We had previously received a whistle blower concerns about the home being cluttered, dirty and not enough staff. We wrote to the registered manager requesting evidence of the staffing numbers for each shift and a copy of staff rota for last two weeks. This information has not been provided to date.
● The registered manager had not carried out regular reviews of people's needs to determine staffing levels for both night and day shift.
● There were no waking staff during night. We raised our concerns with the registered manager who told us, "People have not asked for any help/support in the night since the previous inspection in 2017. We do not have a night waking staff." "We don't need a waking staff." "Sometime my [family member] sleeps over, sometimes [staff] sleep over, sometimes I sleep over." There was a risk to people in the night if they required waking night staff support.
● The service had a call bell system for people to use when they required support. However, there were no records to show if staff responded to request in a timely manner. We saw the person who was on oxygen support, their call bell was not working. We raised our concerns with the registered manager who was not able to explain why it was not working. As said above one person call bell was not working, this meant the person would not be able to call for help at night if they needed support when there were no waking staff..

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staffing levels was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who were suitable for their roles. The provider carried out comprehensive background checks of staff before they started work. These checks included details on their qualifications and experience, their employment history and reasons for any gaps in employment, references, a criminal records check, and proof of identification.

Using medicines safely
● People received their medicines, but these were not managed safely. One person's MAR chart was dated for the period from 22/9/2019 to 21/10/2019. However, when we inspected on 2/10/2019 we found the registered manager had signed this MAR showing as medicine given until 21/10/2019.
● We raised our concerns with the registered manager, who told us, "This was the error made by the Pharmacy." We asked the registered manager why they had not contacted the pharmacy, the registered manager told us, "I have not noticed it until you [inspector] have pointed it out." This meant the registered manager was failing to follow the provider's procedures and national guidance in relation to the safe management of medicines.

● Some people were prescribed medicines on a 'when required' basis (PRN). There was no guidance in place regarding when these medicines should be given, and staff had not recorded the reason why it was given and its effect. The provider's medicines policy had no specific guidance for staff about PRN medicines to administer them safely.
● Staff did not monitor room (where medicines were stored) and medicines cupboard temperatures to ensure that medicines were stored within safe temperature ranges. We raised our concerns with the registered manager who told us, "We do not take temperature of medicines cupboard."

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

Preventing and controlling infection
● People were not protected against the risk of cross contamination as the provider did not have robust infection control policies in place. During the two-day inspection, we identified the registered manager did not have a cleaning schedule in place. Therefore, we were unable to assess if the service was kept clean at all times.
● We raised our concerns with the registered manager who told us, "There is no need for one [cleaning schedule], we are a small care home run by a family. We clean the carpets every day." Despite what the registered manager told us, the home appeared cluttered in the corridors and living room, and carpets unclean in people's bedrooms.
● The provider's infection control policy contained details of the safe disposal of waste, however failed to give staff clear guidance on effective hand washing.

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

Systems and processes to safeguard people from the risk of abuse
● At the time of the inspection, we identified the provider had failed to notify CQC of a safeguarding incident as required. This meant we were unable to take timely action.
● Staff were aware of the procedures in identifying, responding to and reporting suspected abuse.
● The provider had a safeguarding policy in place which gave staff clear guidance on reporting suspected abuse. The safeguarding policy followed the six principles of safeguarding, empowerment, protection, prevention, proportionality, partnership and accountability.
● At the time of the inspection we were made aware of one on-going safeguarding being investigated by the Local Authority Safeguarding team.

Learning lessons when things go wrong
● The provider had a system to manage accidents and incidents and the registered manager completed accident and incident records. However, there was no evidence to suggest how to improve safety and prevent reoccurrences. For example, one person was transferred to another care home, and the reason recorded was the person was rude with staff and passed offensive remarks against them.
● We asked the registered manager what lessons they learned when things go wrong. The registered manager told us, "learnt how to work with safeguarding team." We were not satisfied with the registered manager's response.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- The registered manager carried out a pre-admission assessment of people's needs. This assessment included people's medical, physical and mental health needs, mobility, nutrition, allergies and cultural needs.
- Where appropriate, relatives were involved in these assessments. Despite the above, during the two-day inspection, we identified information contained within pre-admission assessments had not been transferred to people's care plans. For example, about people being at the risk of fire. This meant people were at the risk of receiving inappropriate care increases.
- We shared our concerns with the registered manager who was unable to give us a satisfactory response.

We recommend the provider to seek advice from a reputable source on best practice to complete the care plans in line with the pre-admission assessments and act accordingly.

Staff support: induction, training, skills and experience

- The provider supported staff through training to ensure they had the appropriate knowledge and skills to meet people's needs.
- Training records showed staff had completed training in areas including emergency first aid, food safety, health and safety, infection control, end of life care, moving and handling, falls management, and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Records showed staff were supported through regular supervision and yearly appraisals. Supervision included discussions about staff wellbeing, work performance, and training needs. One member of staff told us, "I get supervisions every three or four months from the manager. We talk about how things are going on with the service users."

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

- People's nutritional needs were assessed, and the registered manager supported them to have a balanced diet. People told us they liked the food. One person told us, "They [The registered manager] make here lovely bread. I am satisfied."
- Staff recorded people's dietary needs and preferences in their care plans. For example, we saw information about someone who needed a mashable diet.
- The provider protected people from the risk of malnutrition and dehydration. We saw action had been taken where risks associated with nutrition had been identified. For example, where people were at risk of malnutrition, records showed that staff sought advice from a dietician and completed food and fluid charts

to monitor their intake.

Adapting service, design, decoration to meet people's needs
● People's bedrooms were personalised and were individual to each person. Some people had brought their personal belongings which had been used to make their rooms familiar and comfortable. People had access to an outside garden area.
● There were accessible toilets and bathrooms in the home. We observed people moving freely about the home, with the addition of signage. Access to the building was controlled to help ensure people's safety.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The registered manager supported people to access local healthcare professionals including their GP , district nurses, speech and language therapist and dietitian. A visiting healthcare professional told us, "He [Registered manager] contacts us very promptly, people are looked after well, and the premises was clean and does not smell."
● A GP visited the home regularly to review people's health needs as and when necessary. We saw the contact details for external healthcare professionals, specialist departments in the hospital and their GP in each person's care record. We saw a GP visited a person on the first day of our inspection.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides 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. The application procedures for this in care homes and hospitals are 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 registered manager was aware of the requirements of the MCA and DoLS.
● Staff we spoke with understood the importance of gaining people's consent before they supported them. One person told us, "They [Registered manager] do what I want them to do. I am satisfied with them."
● Records showed mental capacity assessments had been completed in accordance with the requirements of MCA. People had been assessed as having capacity to make the relevant decision in their best interests.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- The provider did not ensure that people were always treated and supported in a caring way. They did not have effective arrangements to ensure that people always received their call bells, so they could summon help when they needed to and did not have to wait long for care. People were not afforded meaningful activities to keep them simulated and access the community. The fact that the provider did not have robust arrangements around maintaining and ensuring people's safety such as in regard to fire safety and medicines management, also showed that they were not always caring.
- Notwithstanding this, the registered manager was individually caring and showed an understanding of equality and diversity. People told us they were happy with the service and staff were kind and treated them with respect. One person told us, "I like [country name] food, he [registered manager] prepares. I like it."
- People's care plans included details about their ethnicity, preferred faith and culture. The service was non-discriminatory, and people were supported with needs they had with regards to their disability, race, religion, sexual orientation or gender.
- People were encouraged to practice their religion and were supported with their spiritual needs. For example, one person told us, "I do meditation before going to bed every day."

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

- The registered manager involved people and their relatives in the initial assessment and planning of their care.
- The registered manager respected people's choices and preferences, such as the clothes they wanted to wear, their food and drink preferences.

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and their privacy was respected. Staff knocked on people's bedroom doors before entering and they kept people's information confidential.
- People were supported to maintain their independence. We saw people mobilising independently in the home. Staff told us they encouraged people to complete tasks for themselves, as much as they were able to. One person told us, "I dress myself, use electric shaver myself." Another person said, "They [Registered manager] do shaving for me, occasionally I do myself."
- People were well presented. Staff received training in maintaining people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People were not supported to access information in a way they understood. During the inspection we identified there wasn't an AIS policy in place, despite people living at the service requiring support in this area such as information was not available in large font, pictorials, despite the care needs identified for one person requiring such adjustments. We shared our concerns with the registered manager, who told us, "I will update what needs to be updated." This meant people's communication needs were not met at all times.
● We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate information was given to people in a way they can understand. This placed people at risk of harm.

This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 not afforded a programme of meaningful activities according to their needs and preferences to keep them simulated and to access the community to visit places of their choice and interest. There was no activity planner. We reviewed people's daily care logs and found there were several days where people did not leave the service or engage in activities, other than to watch television in their rooms.
● We shared our concerns with the registered manager who told us, "People don't want to go out. If they want to then I'll take them out. One person likes going to the bookies once a month." We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were offered a meaningful activity to keep them stimulated and access the community. This placed people at risk of harm.

This was a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● People knew how to make a complaint and would do so if necessary. The provider had a policy and

procedure for managing complaints.
● The provider maintained a complaints log which showed when concerns had been raised. The registered manager investigated and responded to complaints. On this inspection, we noted a family member was not satisfied with the way their complaint was investigated and responded by the registered manager. We looked at the response sent by the registered manager to the complainant and noted it was not addressed in a professional manner.

We recommend the provider continue to monitor and seek advice from a reputable source on best practice to manage the complaints and act accordingly

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● The registered manager failed to always ensure care plans reflected people's changing needs and gave staff clear guidance on meeting their needs and delivering care and support in the way they wished. Although we found evidence that people's care plans described their likes, dislikes, interests, family and friends, communication, healthcare needs, we also found there was minimal succinct guidance for staff as noted earlier in this report.
● The registered manager completed daily care records to show what support and care they provided to each person.

End of life care and support
● People's end-of-life preferences had been discussed with them, and care plans developed to ensure their preferences in this area were met. For example, one-person funeral arrangements were in place and their preference was to have a priest visit them.
● At the time of this inspection people did not require end of life care support from the provider.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The service did not have a positive culture. The registered manager had not encouraged and empowered people and their relatives to be involved in service improvements through periodic meetings.
- People did not receive a service that was well-led. One person told us, "It is alright for you."

There were systematic and widespread failings of the monitoring and oversight of the service. During the two-day inspection we identified instances where people were placed at risk of harm and the registered manager was unaware of the severity of these risks and how they impacted on people living at Albert Residential Home.

- The registered manager lacked understanding of the necessary audits to be carried out by the service to ensure people were not placed at risk and to monitor the service provision. Therefore, safety issues had been left unnoticed. For example, there were no audits relating to medicines, health and safety, infection control, staffing and fire safety.

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

- The provider had not notified CQC about this safeguarding investigation. There was a safeguarding investigation going on in August 2019, in relation to a person's with pressure sores, who was sent to another home. We raised our concerns with the registered manager who said, "It was only a meeting with local authority." However, when we showed them the correspondence between the local authority and the provider, which clearly stated 'safeguarding meeting'. The registered manager chooses to remain quiet.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate notifications was effectively managed. This placed people at risk of harm. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are considering what further action we need to take in relation to the provider's failure to send notifications.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager did not understand their role and responsibility in line with the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with people's care and treatment.
● In response to our inspection feedback on 27/9/2019 the registered manager wrote to us on 01/10/2019, saying they have updated the PEEP to reflect they were personalised. However, on the second day (02/10/2019) of the inspection we identified, and the registered manager confirmed, the PEEPs had not been updated. In addition, the registered manager in their email of 01/10/2019 said the Fire Rescue services were not that concerned about their fire safety arrangements as it is a small care home with three people, and it is on low risk. However, when we asked the registered manager if they had informed the Fire Rescue Services, a person is on oxygen at the care home, the registered manager said no. The registered manager described the Duty of Candour as" It's a governor. My responsibilities that I have duties to oversee the care home.'" This demonstrated the registered manager did not have a full understanding of what the duty of candour entailed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider sought people's views using satisfaction surveys. We found the responses were positive. Their comments included, "food is good" "I like my music in my room" "I get shower every week."
● The registered manager showed records of meetings with staff. Records of the meetings included discussions of any changes in people's needs and guidance to staff about the day to day management of the service, and coordination with health and social care professionals.

Working in partnership with others
● The registered manager had worked in partnership with a range of professionals and acted on their advice. For example, they worked with dieticians, GPs, district nursing, and Speech and Language therapists.

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 not notified CQC about a safeguarding incident.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not supported to access information in a way they understood. People were not afforded a meaningful activity to keep them simulated and access the community.

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 People were at risk of harm as there were unsafe arrangements for dealing with emergencies in relation to fire safety management. Medicines were not managed safely. People were not protected against cross contamination.

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 There were systematic and widespread failings of the monitoring and oversight of the service.

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive care and support from adequate numbers of suitable staff to meet their needs at all times and keep them safe.

The enforcement action we took:

Warning notice.