Carecall Services Limited

# Roman Wharf Care Home

## Inspection report

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Date of inspection visit:
18 January 2023
23 January 2023

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22 March 2024

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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
Roman Wharf Care Home is a residential home that provides accommodation and personal care for up to 50 people, some of whom were living with dementia. There were 21 people using the service at the time of our inspection.

People's experience of using this service and what we found
Governance systems and processes had failed to make significant improvements to concerns since the last inspection.

People were not protected from avoidable harm or abuse. Incidents of alleged abuse were not always reported and investigated safely, and risks were not managed to help keep people safe. Systems for accidents and incident reporting had not improved since the last inspection and left people at risk. Medical advice following incidents was not always followed.

Medicines were not always administered, stored and documented safely. Extra measures had been taken to protect people from infection, but these were not always effective. Staff recruitment was not always safe. Quality assurance systems did not always identify risks or concerns.

The environment required updating with more dementia friendly signage to support people finding their way around the service. People were supported to eat and drink, but fluid chart recording was not effective. People and relatives were, however, positive about food provided.

People did not always receive personalised care. Staff were not trained in areas relevant to their role, including communication, equality and diversity and person-centred care. People's life histories were not always documented. Written records and staff descriptions of people were not always respectful of people's needs.

Activities were provided for people by an activities co-ordinator, but this was limited in their absence. People were supported to maintain relationships. People's complaints or concerns were responded to. People had end of life wishes documented in their care plans. People felt staff were kind and caring.

People's current needs were documented in their care plans. The staff team worked with other agencies to support with people's needs. Staffing levels were safe, and people told us they felt safe. Staff felt supported by the manager and people told us the manager was approachable.

People were not always supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible and in their best interests, however, the policies and systems in the service did not always support 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 this service was inadequate (published 19 October 2022) and there were breaches of regulation. At this inspection we found the provider remained breaches of regulation.

Why we inspected
At the last inspection, we carried out an unannounced comprehensive inspection of this service on 10 May 2022. Breaches of legal requirement were found. The provider was served with a Warning Notice with a compliance date by when to improve.

We undertook this comprehensive inspection to follow up on action we told the provider to take at the last inspection and to check whether the Warning Notice we previously served in relation to Regulations 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

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.

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

Enforcement and Recommendations
We have identified breaches in relation to safeguarding, risk management, need for consent, governance and staff training and development at this inspection.

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

Follow up
We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains 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.

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|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-led findings below. | **Inadequate** |

# Roman Wharf 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience.

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

Service and service type
Roman Wharf is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Roman Wharf is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager was in post and was going through the registration process.

Notice of inspection
This inspection was unannounced. Inspection activity started on 18 January 2023 and ended on 03 February 2023. We visited the location's service on 18 January 2023 and 23 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all this information to plan our inspection.

The provider had not been asked to complete a Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make.

During the inspection
As part of this inspection we spoke with the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 5 members of staff.

We spoke with 4 people living at the service and 4 relatives. We also observed people being supported at the service. We reviewed a mix of care records of six people, including care plans, risk assessments and monitoring information. We also reviewed 6 staff files which included permanent and agency staff.

We also spoke with a member of the local authority safeguarding team.

Inadequate

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider failed to ensure all safeguarding incidents were identified and referred appropriately. This was a breach of the regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- Systems and processes in place were not effective in protecting people from the risk of abuse.
- Multiple incidents of alleged self-neglect, physical and verbal abuse had not been recorded in relevant incident forms by staff and had not been reported to the manager. These incidents all involved one person and had not been investigated further or reported to the local safeguarding authority to help keep people safe. The provider had already requested the local authority support this person to move to a new home as they had recognised they were unable to meet this person's needs.
- Incidents of alleged abuse recorded in daily care notes failed to always record who were the victims of alleged abuse and how they were supported to stay safe following incidents. For example, one person was described as 'hurting others' in multiple incidents, but it was not clear who these people were or what action was taken to support them. The provider told us that when staff were asked about these daily care notes, where the term 'hurt others' was used, this referred to staff and not other people. However, this had not been established at the time.
- Reported incidents of alleged abuse were not always investigated in a timely manner. It was identified by staff that a person had large unexplained bruising. Although a provider investigation into the incident was completed, the local safeguarding authority was not contacted immediately to seek further guidance to keep this person safe.

The provider had failed to ensure effective processes were in place to protect people from abuse or the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to ensure care and treatment was provided safely and risks were assessed appropriately. This was a breach of the regulation 12 (Safe Care and Treatment) of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Risks to people were not adequately mitigated.
● Actions were not taken to mitigate risks because incidents, such as falls, had not always been recorded in incident forms and raised to the manager for review. Three falls, including two with recorded injuries, had not been recorded in relevant forms and no action to mitigate future risk was taken as a result.
● Medical safety advice from health professionals was not always followed following incidents. A person was recorded as having a fall and sustaining a head injury. It was documented that medical professionals had advised staff should complete hourly checks for a 24-hour period for this person following this fall. Records showed the provider failed to ensure these checks were carried out to monitor the person's wellbeing and keep them safe.
● Risk assessments were in place, but they were not always completed. One person's mobility and function risk assessment did not include up to date information about the support they needed to mobilise. The person's care plan stated they were non-weight bearing, but the risk assessment did not include information such as the equipment needed to support them to mobilise and how many staff were required. Following a discussion with inspectors, the manager updated this risk assessment to include the relevant information.
● Lessons learned were limited as incidents were not always reported and records did not always include key information about the incident. For example, when people expressed anxiety and needed support from staff, it was often not clear what actions staff had taken to support the person. This reduced opportunities to learn from incidents and improve future support.

Using medicines safely
● Medicines administration, storage and documentation was not always safe.
● One person was supported to receive their medicines covertly. Covert medicines are medicines given to people without the knowledge or consent of the individual. This covert administration had been agreed with the GP, however, the provider had not consulted the pharmacy about how this medicine could be safely given covertly. This was not in line with best practice, which states pharmaceutical advice should be sought before covert administration takes place to ensure medicines remain safe and effective.
● Medicines requiring specific management were not always documented and stored safely or in line with best practice. Where this was identified, action was taken to update documentation and storage by staff.

The provider had failed to ensure risks to people were mitigated and that medicines were handled safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe.
● The provider had begun to use a monthly risk register to give an overview of the key risks to people. This included information such as the type of risk, the risk rating, and any recent concerns to support the mitigation of these risks.
● We observed people were supported safely to receive their medicines.

Staffing and recruitment
● Recruitment checks were not always completed safely. Two staff members did not have explanations for gaps in their employment history documented. The provider took action to record information where gaps were identified by inspectors.

● The provider used agency staff to support the service. While permanent staff files we reviewed had Disclosure and Barring Service (DBS) check information in place, we identified two agency staff members who did not have DBS numbers recorded. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider took immediate action to source and record these DBS numbers once raised by inspectors, therefore demonstrating that staff were safe to work at the premises.
● We observed the call bell was responded to in a timely manner and most people told us there were enough staff to support them safely. However, 1 person felt staff did not always respond to the call bell quickly. The manager told us they had not received any concerns about call bell times, but they would look at reviewing them if there were any prolonged responses.

Preventing and controlling infection
● The provider continued to ensure staff always wore face coverings in the service. This was in line with local health protection guidance and was no longer part of national guidelines. We observed some staff not always using their face coverings effectively, such as pulling them down to speak to residents. The manager told us they acted when they saw staff not using face coverings correctly.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
People were supported to have visits from friends and relatives. People and relatives we spoke with did not raise concerns about visiting arrangements. We also observed people with their relatives while on site at the service.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At our last inspection people were not supported with appropriate or specific mental capacity assessments related to their care. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● There was some improvement since the last inspection, but mental capacity assessments were still not always in place. One person who lacked mental capacity to consent to the use of CCTV and covert medicines did not have relevant mental capacity assessments in place. Although, the person had consented to CCTV use in communal areas previously, the person could no longer consent to their care and treatment. Information on covert medicines was also not included in the person's DoLS authorisation, despite the person being deprived of their liberty with covertly administered restrictive medicines.

People were not always supported with appropriate or specific mental capacity assessments related to their care. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● Once raised by inspectors, the manager ensured a mental capacity assessment and best interest decision was put in place for this person. We also saw that other people had recorded consent for the use of CCTV at the service.
● Despite the above concerns, people had DoLS authorisations in place where required and the manager kept a record of ongoing applications and expiry dates for DoLS authorisations.
● Staff understood the MCA. Staff we spoke with were able to describe principles of the MCA and how people were supported to make their own decisions where possible. We also observed these practices taking place.
● Care plans included information for staff about people's assessed needs and information was in place in a timely manner following new admissions. The provider used recognised risk monitoring tools, such as the Waterlow Score to assess the risk of a person developing a pressure sore.

Staff support: induction, training, skills and experience

At our last inspection staff lacked competency and support in order to meet peoples' needs in relation to moving and handling. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff did not always receive relevant training and support required for their role. Staff had not received training in areas such as communication, person-centred care, equality and diversity, privacy and dignity, or learning disability and autism support. This limited staff's ability to support people using the service effectively, including those living with dementia. Once raised by the inspector, the provider took action to enrol staff onto training on autism and learning disability support.
● There was not an effective induction programme for new staff to ensure staff had the skills to meet people's needs. We identified members of staff who had either no records or incomplete records of an induction taking place. One staff member had not received safeguarding training within the first 6 weeks of employment which was not in line with NICE best practice guidelines. The manager had developed a new induction system with clear timescales for staff which was put in place during the inspection.
● New staff were enrolled on an in-house training programme but were not supported to complete the care certificate or an equivalent training programme which covered all areas of the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Most staff had not received 1 to 1 supervisions and appraisals to review their practice and discuss development. We identified only 2 staff members had received 1 to 1 supervisions in line with the timeframes set by the provider's supervision policy. In a recent supervision record we reviewed, professional development had also not been discussed. Inspectors discussed this with the manager and they updated their supervision template to include professional development.

The provider had failed to ensure staff received appropriate support, training and supervision. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff had received up to date moving and handling competencies since the last inspection.

● Staff observed more experienced members of staff when they first joined the service to support them to get to know people's needs and worked alongside them. Staff told us this supported them in their role and they were able to ask questions about people's care.

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

● Fluid charts were not always used effectively. For example, 2 people had fluid intake charts in place due to a dehydration risk but these charts did not have a target intake amount to inform staff how much they should be offered to drink to ensure they were safely hydrated. However, we did not see any evident impact on people because of this.

● People's weights were recorded and reviewed regularly. People's care plans included information on actions for staff to take in the event there were concerns about people's weight, such as the GP.

● Staff supported people to eat and drink in line with their assessed needs.

● People and relatives were generally positive about the quality and choice of food provided. One person told us, "I do like the food. I had the lamb today. With red cabbage. When [staff] come around to tell you what food is on, they give you the 2 options but also ask if there is anything else would prefer."

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

● There had been some improvement to the service design and decoration following concerns being raised at the last inspection. The provider had marked dementia friendly signage as complete on their environmental improvement log, but dementia friendly signage was still not always in place. While there were signs for some rooms, some people's bedroom doors did not include their name or relevant photos to support them to find their bedrooms.

● Some areas of the service required updating to improve aesthetics. For example, 1 person's room had a pull-down blind which had heavy signs of wear. There was also a wooden external door panel in the garden area which was unsightly.

● The provider kept a log with any planned work and timescales to completion. This included completed works for a bath which was found to be not working at the last inspection. There was evidence of continued work at the service to adapt it to people's needs.

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

● As outlined in the safe key question of this report, advice from health professionals was not always followed safely. However, we did also see evidence of some partnership working to support people with their care.

● The manager or staff took part in frequent multi-disciplinary meetings with local healthcare professionals to raise any concerns about people's care and support.

● Staff also supported people to access healthcare services. For example, a person told us they were due to have an eye procedure and a member of staff was going to attend with them.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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; Respecting and promoting people's privacy, dignity and independence

- The provider had not always promoted a kind and caring culture. For example, language used in conversations with staff and in care notes was not always respectful of people's needs. Staff we spoke with described one person as having a 'violence issue' and an aspect of their care being a 'battle'.
- Staff did not receive equality and diversity and person-centred care training from the provider. We discussed this with the manager, who stated they would be implementing this along with changes to their induction programme.
- People told us staff were kind and caring and got to know them well. One person told us of their surprise the staff had remembered their fondness for a certain type of food being served for lunch that day.
- There were other instances of staff providing caring support people. One person told us," [Staff member] has been really good. My relative was in hospital last week but I couldn't find anything out. [Staff member] made some calls and got me some information."

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

- Independent advocates to support decision making were in place for some people but not others. Inspectors discussed this with the manager who subsequently sought access to advocacy for 1 person.
- People were supported to make their own decisions. People we spoke with told us they were supported to make their own choices. Staff supported people to make their own decisions and there was evidence of people's preferences recorded in their care plans which informed the care and support they received.

Requires Improvement

# Is the service responsive?

## Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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; 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

● Although care plans included a good level of information on people's current needs and preferences, people's life histories were not always detailed. This meant new staff members could not learn about people's pasts from care plans to support development of rapport and relationships.
● The provider had not supported staff to complete person-centred care training, and this was reflected in elements of the service which were not personalised. For example, the service had modern music playing throughout the day in the lounge and dining area, but there was no evidence this was the choice of people living at the service.
● The service had an allocated activity co-ordinator who was on leave at the time of the inspection visits. People had access to a range of activities taking place through the co-ordinator, such as card making, singing and biscuit making. In one case, a person was supported to listen to music which was reflective of their cultural background. People told us these activities were good for their wellbeing.
● People told us they were supported to maintain personal relationships. One person told us, "They invited my relative for Christmas lunch. They are in a wheelchair and if they couldn't get here due to bad weather [a staff member] said not to worry and they would find someone that would be able to go get them if it was a problem."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were not always met. As outlined in the effective key question, dementia friendly signage was not always in place for people to help them find their bedrooms.
● Staff had not completed training in communication to support their interactions with people. However, staff were aware of alternative methods of communication. For example, a staff member told us they would look out for people's body language to see if they were in pain or uncomfortable and not able to communicate this verbally.
● People's communication needs were documented in their care plans. For example, one person was documented as being hard of hearing and staff used a white board to support communication with them.

● The manager understood the need to follow the Accessible Information standard and the need to make information accessible for people. This was also reflected in policies, such as the complaints policy.

Improving care quality in response to complaints or concerns

● People told us they knew how to make complaints or raised concerns. One person told us they had issues with receiving other people's clothes from the laundry. This had been raised to the manager and they had taken action to rectify this.
● We saw recorded evidence of people's complaints and these concerns being acted upon.
● There was an up-to-date complaints policy in place.

End of life care and support

● At the time of the inspection, there was no one on end of life care. People had their end of life wishes recorded in their care plans, where they had agreed to disclose this information.
● Do not attempt cardiopulmonary resuscitation (DNACPR) orders and ReSPECT forms, detailing recommendations about emergency treatment, were present in people's care plans. This supported staff to pass this information onto healthcare professionals in the event of a medical emergency.
● Staff received end of life training 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 our last inspection we rated this key question inadequate. The rating for this key question has remained 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection systems to manage safety and monitor the quality of the service were either not in place or effective. This placed people at risk of harm. This was a breach of the regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider had failed to make significant improvements to their ratings over consecutive inspections. Although this service was a newly registered location on 22 March 2021, it has been run and managed by the same group of directors since 01 September 2014. Over the last 3 inspections, the service has been in breach of regulations and has failed to achieve a rating greater than requires improvement. This included an inadequate rating at the last inspection. There was an ongoing failure to comply with the fundamental standards expected of services.
● The provider had failed to ensure an effective system for identifying, reporting and analysing accidents and incidents was in place. As outlined in the safe key question, several accidents and incidents had not been reported or investigated which was a continued concern from the last inspection. There was a failure to improve this system and this left people at risk of unsafe care.
● Quality monitoring systems were not effective. For example, there was a failure to ensure repositioning was recorded effectively. Two people who had a skin integrity risk were assessed as needing repositioning every 4 hours. However, there was no system in place to ensure this was being recorded. We identified several occasions where staff had failed to document repositioning in the required timeframe. The manager told us they felt the repositioning charts did not take into account when people received personal care, but no actions had been taken to address this.
● Staff meetings had taken place, but minutes for the last 2 staff meetings had not been recorded. This meant that copies of key messages could not be distributed to staff members who were not able to attend the meetings. This risked staff not being kept up to date with changes to requirements or important information relevant to their roles.
● The provider failed to ensure their policies were followed and failed to set out clear processes to ensure regulatory compliance. For example, the provider's supervision policy stated that staff should receive

supervisions at least every 4 months but this had not taken place. Further to this, the provider's training and development policy did not outline a clear process with timescales for staff training when they joined the service. This was demonstrated by a staff member not receiving safeguarding training within 6 weeks of commencement, as outlined in the safe key question.
● Contemporaneous records relating to staff were not always kept. As outlined in the safe key question, two agency staff members did not have Disclosure and Barring check numbers recorded on their staff profiles. The manager sourced these numbers once raised by inspectors.

The provider failed to ensure systems and processes were in place to ensure good governance. This was a breach of the regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt engaged about their care and that when they raised concerns to the manager, actions were taken to resolve this. For example, 1 person told us they were being given other people's clothes from the laundry, but the manager had taken action to rectify this.
● The service did not have a registered manager in place. However, the manager had made an application to become registered.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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.
● Reporting and recording of accidents, incidents and risks was unreliable and this limited the service's ability to provide an open and person-centred culture. Although there was evidence of the manager contacting families regarding documented concerns, the provider was not always aware of incidents, or relevant details of incidents, as they were not always reported. This meant information could not be shared with people, relatives and staff when incidents occurred. Relevant action could not always be taken to personalise people's care to reduce risks and achieve good outcomes for people.
● Staff had not received training in person-centred care and equality, diversity and human rights which limited their ability to provide personalised care.
● Staff told us they felt the manager was open and honest about what was expected of them. They said that they felt comfortable approaching the manager with concerns and supported in their roles.

Working in partnership with others
● Although there was evidence of partnership working, this was not always effective. As outlined in the safe key question, medical advice was not always followed from health professionals.
● The manager told us they worked closely with the local authority and other healthcare professionals. We saw evidence of the manager taking part in regular multi-disciplinary team meetings with healthcare professions to discuss people's needs. There was also documented input from other healthcare professionals in people's care plans.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure relevant mental capacity assessments were in place. |

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<br><br>The provider failed to ensure that risks to people were mitigated and medicines were managed safely. |

**The enforcement action we took:**

Requirement 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<br><br>The provider had failed to ensure effective processes were in place to protect people from abuse or the risk of abuse. |

**The enforcement action we took:**

Requirement Notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to ensure systems and processes were in place to ensure good governance. |

**The enforcement action we took:**

Requirement Notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure staff received appropriate support, training and supervision. |

**The enforcement action we took:**

Requirement Notice