A Kilkenny

Belper Views Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Belper Views is a residential care home providing personal for up to 25 people aged 65 and over. At the time of the inspection the home was supporting 18 people. The care home accommodates people across two floors. The upstairs consists of bedrooms and a communal bathroom. Downstairs there are further bedrooms and communal toilets or bathing facilities. There were also two communal lounges, a dining room and open access to a secure garden with seating area.

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

There was no registered manager and the provider had limited oversight of the home. Audits had been completed, however they had not identified where things needed to be changed to drive the improvements. Staff did not receive the support they required to give them direction and guidance in ensuring people received person centred care. Notifications had not been completed to reflect events which had occurred within the home. Some partnerships had been developed, however further consideration needed to be made to reflect people's religious or individual needs.

People had not always been protected from the risk of harm. Staff had received training however there was no clear structure to report concerns and ensure actions were taken. Risk assessments had not always been completed for all aspects of risk, leaving some areas of concern with no risk reducing measures. There were not always sufficient staff, and we could not be sure they were deployed to meet people's needs. Medicines were managed safely, however the stock and use of topical creams needed to be monitored. Improvement's had been made in protecting people from the risk of infection, however some aspects were not reflected in daily practice. Lessons had not always been learnt to ensure continued improvements.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. We made a recommendation to the provider following current guidance in relation to this area.

Staff had received training; however, their knowledge had not been embedded into their practice., which meant people were at risk of not receiving care in a safe way. People's dignity had not always been maintained or people's choices considered.

Care plans had not all been completed to ensure that the care was person centred and reflected individual's needs. Staff were not always responsive when people required care. Some care plans in relation to end of life had been completed and reflected choices at this time of people's lives.

People enjoyed the meals they received and felt comfortable within the home. Relatives could visit any time and were made welcome. People had established positive relationships with the staff.
Complaints had been addressed.

When people required support with their health care, referrals were made in a timely way and the support was followed up by the staff.

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 Inadequate (published 3 April 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough, improvement had not been made or sustained and the provider was still in breach of regulations.

Why we inspected
The inspection was brought forward to review the concerns we had raised at our last inspection. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. We have identified breaches in relation to seven areas which relate to the good governance of the home, people's care, dignity and ongoing safety at this inspection.

You can see what action we have asked the provider to take at the end of this full 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 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 and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Belper Views 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 inspection was completed by an inspector and an assistant inspector.

Service and service type
Belper Views 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 provider had commenced the process of recruiting a manager who will then register with the Care Quality Commission. However, in the absence of their registration, the provider is 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.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, to support the planning of this inspection. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority, clinical commissioning group (CCG) and other

professionals who work with the service. We used all of this information to plan our inspection.
On this occasion we did not ask the provider to complete a Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. However, we gave the provider the opportunity during the inspection to inform us of any improvements they had made.

During the inspection-
We spoke with eight staff, these included care staff, senior care staff, domestic staff, the cook and the consultant working with the provider. The provider was present during the inspection and for the feedback of the inspection. We spoke with three people who used the service and two relatives. We also spoke with a trainer who was working with the staff at the home.

We reviewed a range of records. This included five people's care and multiple medicine records. We also reviewed the process used for staff recruitment, various records in relation to training and supervision, records relating to the management of the home, and a number of policies and procedures developed and implemented by the provider.

After the inspection –
We continued to seek feedback in relation to the home and the care provided. We contacted two health care professionals and spoke with staff at the local authority.

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 inadequate. At this inspection this key question remained the same.

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not, enough improvement had been made and the provider was still in breach of regulation 12.
•Risk assessments had not always been completed to reflect how risks could be reduced. For example, one person enjoyed a cigarette and there was no risk assessment to clarify how the person was supported to ensure they would be safe during this activity. Other people required equipment to support them to move. How to use this equipment using the health care professional guidance had not been included in the assessment.
•Some risk assessments had been completed in relation to people's specific health conditions. However, these did not contain the required information to ensure swift action would be taken in the event the person's health condition deteriorated.
•We raised these concerns in relation to risk as our last inspection and they had not been addressed. This meant we could not be sure that lessons were learnt when things went wrong.
•People's continence needs had not always been considered. For example, one person used a catheter. We observed staff were not responsive when this required attention. There were no records to show when this had last been emptied and there was no risk assessment to reflect current practice and good catheter care.
•Equipment was not always safe to use. For example, the stand aids emergency button was missing. This meant should the equipment become stuck in a position or have a fault whilst in use, the emergency button could not be activated. In addition, the only hoist within the home had two faulty wheels which showed some part of the rubber was missing. This meant the brakes on the hoist would not be effective. We asked the provider to take immediate action and remove the stand aid from use and replace the hoist. This was completed on the day of the inspection.
•Some people required specialist cushions to reduce the risk of sore skin. We found these were not always used as recommended. For example, when people sat in the one position for long periods of time or when they transferred from the chair to the wheelchair.
We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate 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.

Using medicines safely

• At our last inspection we raised several concerns within the breach of Regulation 12. At this inspection we saw that improvements had been made. However, continued monitoring was required to ensure this was maintained.

• We saw an audit had been completed and these areas were being addressed. However, we found some concerns in relation to the levels of stock which had been recorded and in staff ensuring there was enough medicine for people's prescribed needs. The person would have run out of their medicine before the next cycle commenced.

•Some people had topical creams, however a clear system of recording the use of these had not been established. We found some creams had not been dated on opening and for some people there was no medicine administration record for the cream.

•Staff had received training and their competency was being checked to ensure they had retained the information and were following current guidance.

Staffing and recruitment

•At our last inspection we raised concerns around staff being available for people in the communal areas. At this inspection we found this practice continued. We saw the lounge was not always supervised and some people told us they had no way of attracting attention when they needed some assistance. There was a call bell on the wall, this was not always accessible to people who could not move independently.

•Staff were not organised in managing their time, and this was reflected in them being task focused. For example, staff were unsure who was support who with personal care and there was no agreed approach to supervising the lounge. When we discussed this with the staff they told us the introduction of the new paperwork had impacted on the way they now worked.

•The provider had a dependency tool which reflected the level of staff to support people's needs. However, when we reviewed the staff rota for the previous week and the current week and found on five occasions there was not the agreed three staff working. This meant that the provider had not provided the assessed number of staff to deliver safe care.

•The provider had used agency staff to support the staffing levels on some occasions. However, when the number of established staff were not available agency staff had not always been used to provide a consistent approach to ensure the staffing levels were maintained.

We found no evidence that people had been harmed however, systems were not in place to demonstrate there were sufficient staff. This placed people at risk of harm. This was a breach of regulation 18 (1) (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to assure us that people were protected from the risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had been made. Staff had received training in safeguarding and were able to discuss with us the different areas they would report to avoid the risk of harm to people. However, due to the lack of manager and provider oversight we could not be sure areas of concern would be reported. For example, we saw evidence of unexplained bruising or when there had been an unfriendly exchange between people. This meant that if staff had a concern there was no current process to ensure this was dealt with appropriately.

Preventing and controlling infection

• Improvements had been made to protect people from the risk of infection. We saw cleaning schedules had been introduced, however, these had not always been completed as directed. We also saw one of the toilet floors had holes in it, this meant we could not be sure this surface could be cleaned effectively.

•Staff had access to personal protective equipment. We saw staff used gloves and aprons when they provided personal care or food preparation. Although staff had access to gloves and aprons when they provided care, we observed that infection control guidance was not always followed with regards when to change them. For example, we saw staff carrying soiled laundry without wearing gloves.
•The kitchen and food preparation area was well maintained There was a five-star rating from the food standards agency, which is the highest possible rating. The food standards agency is responsible for protecting public health in relation to the safe handling of food.

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

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff had received the required training for their roles. This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not, enough improvement had been made and the provider was still in breach of regulation 18 (2)
• The staff had received increased training in many areas of care to support their role. However, we found that the training was not always been reflected in their practice. For example, when staff used equipment for moving people we saw they were not confident in fitting the slings on to people to ensure any transfer they provided was safe. On two occasions we saw staff having to readjust the sling several times as they had fitted it correctly. We also saw the technique of lifting a person under the arms being used. This places the person at risk of an injuring to their arms. These concerns show the guidance from the health and safety executive 'Moving and handling in health and social care' was not being followed.
•One staff member had not received moving and handling training and we saw this staff member supporting people to move with walking aids or wheelchairs around the home.
We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• Capacity assessments had been completed and when people lacked capacity the decision had been made through a best interest meeting. For two people this had reflected the need for a DoLS referral to be completed and these had been authorised. We discussed with the provider the need for other capacity assessments to be completed to reflect specific decisions, such as when people required equipment to move.
•Staff had received training in MCA, however not all the staff we spoke with understood the importance of giving people choices and obtaining their consent before care was commenced. Staff were not aware of who was subject to a DoLS or how decisions had been made. We discussed this with the provider who had introduced a trainer who was reviewing staff competencies in this area and other areas of training the staff had received.

We recommend the provider consider current guidance on MCA and DoLS and review these in conjunction with the training staff received.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•Information on current practice guidance in relation to long term illnesses or conditions had been included in the care plans. The printed information was included in the care plans to provide staff with additional knowledge about these conditions. However, this information had not been reflected in the care plans or risk assessments. For example, when supporting people with diabetes or catheter care. This meant we could not be sure that this knowledge had influenced best practice approaches to care.

Supporting people to eat and drink enough to maintain a balanced diet
•People enjoyed the meals, and their dietary needs had been provided in the meals on offer.
•There was a choice of meals and a picture menu had been introduced. This included offering people a choice of sandwiches for their tea and using pictures to explain the fillings.
• People had been consulted on the menu and their choices had been incorporated into the menu. For example, some people had requested a curry, and this was offered as an alternative from the casserole option.
•People's weights had been monitored and these had been reviewed to ensure people had received the correct dietary needs. For example, one person required fortified food when they had periods of not eating.
•People were provided with snacks and refreshment throughout the day.
•One relative told us, their relative had reduced their weight which had a positive impact on their diabetes.

Adapting service, design, decoration to meet people's needs
•We saw the home had a programme of refurbishment and the home was warm and comfortable in its decoration.
•People had been able to personalise their space and enjoyed items of interest to them were placed nearby when they sat in the communal spaces. Pictures of the person was displayed on their bedroom doors to support people to navigate to their room. One person said, "I like my room, I have a lovely view."
•People enjoyed the outside space, which offered seating and a cover area to protect people from the weather.

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

•The care plans now included a section for health and social care professionals to complete following their visits. A health care professional told us they now complete the information as well as inform the staff so

that they are aware of people's needs.
•People's needs were responded to swiftly. A health care professional said, "Staff here contact us when people need medical support and they are always appropriate." They added, "Staff know people and they will be assertive in asking for medical checks."
•We reviewed records which showed that when people had received care this was documented. When requests were made for recording weights or changes these had been completed.

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 requires improvement. At this inspection this key question remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
At our last inspection the provider had not always ensured people's dignity was maintained. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not, enough improvement had been made and the provider was still in breach of regulation 10
•Staff had not always considered people's dignity when providing care. For example, covering people's legs when they used equipment.
•At night the provider had introduced a system which reflected people were checked on an hourly or two hourly basis. We recognise for some people this is an important safety check, however for others this is an infringement on their privacy. Consideration had not been taken to speak with people and discuss the support they may require during the night.
•Staff were not always discreet when discussing people's needs, this showed a lack of respect for the individuals.
•In addition, staff did not always consider forward planning to avoid further embarrassment for people. For example, when using the bathroom, we saw that some equipment had not been removed, which meant there was limited room, and this had an impact on the toilet door not being able to be closed in a timely manner.
We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
•Some people had been involved in their care planning and their views recorded, however, other care plans had not been completed. This meant that not everyone's wishes had been reflected in the care they received.
•Staff were very familiar with people and this had a mixed response to when people made decisions. We reviewed night records and they reflected one person had requested to get up during the night and had enjoyed a snack, however another person had requested to get up and they were told to remain in bed. This meant we could not be sure people's chosen choices were considered.
•Relatives told us they felt welcome and all those who visited were greeted warmly and offered

refreshments.

•Staff had established relationships with people and were able to relate to their life interests and family connections. One person told us, "I like the staff they are very friendly."
•People told us they enjoyed the company of the staff. We saw some positive interactions with people which showed staff cared about the individual. For example, we saw one staff member brushing a person's hair and speaking with them in their room. We also saw some people were offered to have an afternoon rest after their lunch, when they wished to do this they were supported to their rooms.

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 requires improvement. At this inspection this key question remained the same.

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
At our last inspection the provider had not completed people's care plans to reflect people's needs and there were limited activities available for people. This was a breach of regulation 9 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not, enough improvement had been made and the provider was still in breach of regulation 9.
•Some care plans had been completed and had included people's views on their care needs. These plans were person centred and showed details in the care people required. However, other people had limited details in their care plans and many sections had not been completed.
• Some people expressed behaviours which could challenge. Some people had a plan in place to support them, however others had no plan. We saw that when an incident had occurred it was recorded, however these had not been used to develop the behaviour support plans. We saw how one plan reflected how a person often had skin which irritated them causing them to scratch and affect their mood. This person had cream to relieve these irritations, however from the records we could not be sure these had been applied.
•We found that care plans had not always identified people's equality needs. For example, some people had previously had a strong spiritual belief. This had been recorded, but no action taken to provide an opportunity for people to continue to follow their belief. Other people had expressed a sexual preference, but this had not been recorded on the care plan and their needs considered.
• We also saw that some aspects of people's care plans were not linked up. For example, when people lacked capacity there was no detail provided in how they would be supported with decisions or how this impacted on their care.
We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. 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.

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.
•There were picture menus available for people and some signage around the home. However, we discussed with the provider other aspects of communication they could use to support people to understand

information. For example, information in an easy read format for complaints and other details about the home. The provider agreed to review this area.

Supporting people to develop and maintain relationships to avoid social isolation
• At the last inspection there were limited opportunities for people to engage in areas of interest. We saw that there had been some improvements to the activities on offer, with the introduction of a monthly exercise group and outside entertainers.
•There was an activities coordinator who had developed a programme for people. However, when this staff member was not working, we observed there was no spontaneous moments for people to enjoy conversations or activities with staff when they had a spare five minutes.

Improving care quality in response to complaints or concerns
• There was a complaints policy displayed in the front of the home. Any complaints which had been received had been responded to.
•People and relatives told us they felt able to raise any concerns they may have.
•The provider told us they would be developing the policy to ensure all concerns, informal or formal would be dealt with by a written response.

End of life care and support
•End of life care plans had been completed for some people. Where these were in place they reflected individual needs, including where they wished to spend their last days and any associated health care plans. The details also included any agreed arrangements they may have once the person had died, for example any funeral plans.
•The provider agreed to ensure that each person had an end of life plan.

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 inadequate. At this inspection this key question has now remained the same.

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
At our last inspection the provider had failed to provide assurances in the governance of the home. This was a breach of regulation 17 (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not, enough improvement had been made and the provider was still in breach of regulation 17
•There was no registered manager at the home. The provider had some interim arrangements to support the running of the home after the registered manager had stepped down from this role. However, at the time of the inspection there was no clear management of the home. A consultant had been contracted by the provider to support the home in meeting the regulations and they had provided some direction. The provider had told us they were recruiting a manager and an advert had been placed.
•There was limited guidance for staff. At the beginning of each shift staff identified who was to lead the shift, however, we found that there was limited organisation in managing the needs of people. For example, we had to ask staff to support someone with their care needs. We also had to ask staff to support a person who had been identified as being at risk of falling when they got up from their seat and no staff were present.
• Audits had been developed, however they had not reflected some of the areas of concern we had observed. For example, the health and safety audit completed on the 26 June 2019 had reflected all equipment was in good working order. We found two items to be faulty and in need of immediate repair. Medicine audits had not identified all the stock issues, some people were at risk of not having enough medicines at the end of their medicine four week period. This had not always been identified and resolved swiftly.
•Accidents and incidents had only been audited for one month (May 2019). Following the audit there was no analysis to consider any action to reduce people's risks. We identified when one person was at risk of falls, a sensor mat had been placed in their room to reduce the risk. However, this mat was removed on the assumption the falls had reduced. After several falls over three days the sensor mat was replaced. No analysis had been completed in relation to the falls which would have reflected the trends of those people who were at risk.
• The provider did not continuously learn and improve from events or through the use of the audits.
We found no evidence that people had been harmed however, systems were either not in place or robust

enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
At our last inspection the provider had failed to provide us with notifications in relation to the service. This is a breach of Regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. At this inspection we saw improvements had been made, however these had not continued, and the provider was still in breach of regulation 18.
•Notifications had been received for the period March to May 2019, however since this time we have not received notifications in relation to events which affect the people or the service. For example, safeguards, hospital admissions and deaths. This was due to the lack of management and over sight of the home.
•Staff told us they had been supported with supervision and we reviewed records to confirm this had occurred, however these were during the interim period of a manager. However, they were unable to tell us who was in charge and running the home. This meant we could not be sure if any problems occurred they would be dealt with swiftly or in line with the regulations.
•The provider had commenced meetings with the interim management. However, the records reflected home improvements and maintenance elements and not the management and running of the home. The provider visited the home daily but had limited oversight in relation to the requirements in meeting the regulations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
•People told us they enjoyed living at the home. One person said, "It friendly and I enjoy the food."
•There had been some improvements to elements of the service, however we still had continued concerns for people's safety, personal centred needs and ongoing respect for individuals.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People had been consulted on the meals they wish to receive. The consultant had prepared questionnaires which was planned to be distributed to people, relatives and professionals in the July 2019.
•Some people had been consulted about their care and this had been documented in the care plans, however other people had not had this opportunity. There care plans had many blank documents and staff relied on their own knowledge to provide care.
•The consultant had introduced a handover book to ensure information of importance was cascaded when staff commenced their shift. We observed a handover, although each person was briefly discussed in terms of the morning's events, no direction was provided in to what care people needed to receive. For example, several people had not eaten their lunch, there was no agreed approach as to who would ensure they had a meal. Also, which staff would be supporting which person, to ensure that people's personal needs would be covered.
•Staff were informed the hoist was not to be used, however alternatives to support people were not discussed. This meant staff were not provided with the guidance they required to ensure safe care to people.

Working in partnership with others
•Some partnerships had been developed with health and social care professionals
•Further partnerships could be considered with the local church to support people's spiritual needs and other opportunities for people to engage in the local community.

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 always reported significant events that occurred in the home. We had not received notifications from them for important information affecting people and the management of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People had not always received safe care and treatment to ensure the care was individual to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always respect to ensure their dignity was maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment to protect people from the risk of harm.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was limited oversight of the running of the service. Effective systems were not in place to assess, monitor and improve quality of care. People were not engaged in sharing their opinions about the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient staff to meet people's needs and the staff did not always have the knowledge and skills to provide to support their role.