Four Seasons Homes No.4 Limited

# Osbourne Court Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| 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
Osbourne Court Care Home is a purpose-built residential care home providing personal care to 67 people at the time of the inspection. The service can support up to 69 people.

People's experience of using this service and what we found
There were failings across several areas of the service resulting in breaches of regulations. Governance systems were ineffective and did not identity issues found on this inspection. Feedback about the registered manager and staff team was mixed. Where issues had been found by the local authority or by internal monitoring, these had not been fully resolved.

People and relatives were not always happy with the care and support they received. People at times did not receive the appropriate personal care. The admission process to the home needed to be addressed so that people had a positive start to their stay. Some staff were friendly, and some were attentive to people's needs. However, at times staff were not responding to people when they asked for help or showed signs they needed support.. People, their relatives and staff told us there were not enough staff to meet people's needs. Staff were trained and felt supported.

People felt safe but staffing issues made them feel more at risk. Staff were aware of how to promote people's safety. Regular checks were not in place to ensure staff worked in accordance with training and in accordance with regulations. Unexplained injuries were not always reported or fully investigated. Equipment was damaged making it difficult to clean it effectively.

The environment required redecoration in some areas. Many walls and areas of woodwork were damaged, and bathrooms were not always accessible or pleasant to use. Some bedrooms and corridors had very stained ceilings from water damage. Some people enjoyed the activities that were provided, others felt they needed to be improved. Aids and tools needed to be considered to assist people with communication. People told us they food was ok, and they had choice. However, more consideration needed to be given to the mealtime experience and accessibility of drinks and snacks. Weights were monitored, and action taken when needed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. The registered manager was not clear on the Mental Capacity Act and Deprivation of liberty safeguards. People were not always treated with dignity or respect and confidentiality was not always promoted. This was because care records were left in corridors.

People were not fully involved in planning their care. People had end of life care plans, but these were clinical and did not explore how people's emotional wellbeing would be promoted at the end of their lives. Complaints were recorded as being responded to appropriately. Feedback was sought through meetings

and there were opportunities to complete surveys. However, relatives told us they had not been approached for feedback directly.

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

The last rating for this service was Good (published 8 November 2018). At this inspection the service has deteriorated to Requires Improvement.

Enforcement
We have identified breaches in relation to person centred care, promoting people's safety, treating people with dignity and respect, consent and governance systems.

For requirement actions of enforcement which we are able to publish at the time of the report being published:

Where we are taking or proposing to take enforcement action but cannot yet publish the actions due to representation and appeals process. 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.

Why we inspected
The inspection was prompted in part due to concerns received about people not receiving care that met their needs. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see all sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

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.

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

We always ask the following five questions of services.

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

# Osbourne Court Care Home

**Detailed findings**

## Background to this inspection

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

Inspection team:
The inspection was 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:
Osbourne Court Care 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 who was registered with the Care Quality Commission. A registered manager 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.

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 and professionals who work with the service. We did not request a provider information return for this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with 10 people who used the service and four relatives about their experience of the care provided. We spoke with the registered manager, three of the providers quality team members and 13 members of staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We looked at quality assurance records.

Requires Improvement

# 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 Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risk assessments in care plans related to core elements of care such as transferring from bed to chair and having a shower. Risk of developing pressure ulcers and choking was assessed as well as use of bedrails. These were kept under regular review.

● There were systems in place to manage fire safety. Staff had a good understanding of what they needed to do in the event of an emergency. Most staff attended fire drills, however there was not an overview of this, so the registered manager could identify who needed to attend a drill. The registered manager started adding this to the training matrix during the inspection.

● Accidents and incidents were reviewed for themes and trends. However, some bruises, skin tears and incidents had not been entered onto the provider's monitoring system. The registered manager was not aware of some incidents we found. This meant that they were unable to accurately test the quality of the service and identify themes.

Systems and processes to safeguard people from the risk of abuse

● Most people told us they felt safe. However, people said that staffing at times made them feel unsafe. One person said, "There are not enough carers to keep them safe." They went on to say, "If there should be two carers for me but there is only one then I go and get the nurse to stand in as support, but I go and get her, other people can't do that." One relative said, "[Person] is safe here generally. They check on them regularly and if there is a problem they phone me straight away."

● Staff had received training on how to recognise and report abuse. They were able to tell us what they would do if they had concerns about a person's welfare and information was displayed in the home. We saw records of a supervision with a staff member who had delayed in reporting a potential safeguarding incident. They had their training refreshed and the incident documented on their file.

● However, unexplained injuries were not always investigated appropriately. We found two injuries on the body maps we reviewed that were not on the internal monitoring system and another two unexplained injuries on the providers monitoring system that had not been investigated.

Using medicines safely

● People received their medicines when needed and in accordance with the prescriber's instructions in most cases. However, for one person we found that they had missed four doses of an anxiety calming medicine. We also found that there were some gaps in signatures.

● Other records tallied with stock held in other medicines checked and staff had received training.

● There were daily checks on medicines management within the home and a monthly audit. However, these had not found any issues.

Preventing and controlling infection

● Some equipment seen was damaged and dirty. For example, a shower chair was stained, and the covering was torn. This meant that it could not be cleaned effectively. We saw hoists were not clean and some bumpers on bedrails were also torn.

Due to unexplained injuries not being consistently reported and investigated appropriately, infection control shortfalls and gaps with medicines, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People gave mixed views about if there were always enough staff to meet their needs. One person said, "They come quite quickly most of the time if I ring my bell, they have never not come if I have used my bell." Another person said, "I need two people to help me and sometimes they manage with one, that's why I don't want to get out of bed so much."

● Relatives agreed there were not always enough staff. One relative said, "The staff here are fabulous, but they are spread so thinly that it affects peoples' care." Another relative said, "On paper there are enough staff, but weekends are very bad and there is no senior management on the units then. I know there aren't enough staff because I am here every day and I see them looking for help and overhear them saying to people 'we are short of staff' and I often see relatives looking for staff for help with the toilets and there is no one to help."

● Staff said there were not enough staff to support people. One staff member said, "People are not able to get up out of bed often enough." Another staff member said, "The result of the reduced staffing levels is that we are constantly rushed providing support for people to have personal care and eat. If we are rushed and stressed constantly we will not have as much patience and tolerance as we need."

● On arrival the registered manager told us that the provider had instructed them to reduce staff by one on each unit during the afternoon. We discussed this with the provider's quality team members, about the decision to reduce staffing on a unit which mainly supports people living with dementia. People living with dementia can become more unsettled during the afternoon and evening. The provider's representative agreed that this would need more of a review.

●On the day of inspection, we saw that staff were around but often gathered in groups chatting rather than attending to people. We saw that several family members came at lunchtime. One relative said, "I try to get here at lunchtime to make sure [person] eats and to ease the burden on the staff trying to help people to eat."

● We found that some issues were not identified by the monitoring systems, so this meant that the dependency tool may not have been accurate. We discussed this with the management team and asked that they review all people's needs and records to ensure accuracy.

We recommend that the provider completes a robust review of staffing needs and deployment at the service.

●Recruitment processes were followed. This helped to ensure that staff employed were suitable to work in a care setting. However, the management team were reminded to sign and date identity checks to validate authenticity.

Learning lessons when things go wrong

● Where there had been incidents, accidents and complaints, the registered manager shared this information with the staff team through meetings and group supervisions. However, this had not been effective in all cases as there had been reoccurrences. In addition, not all information was known by the

registered manager. For example, one person was recorded as expressing behaviour that challenged others and the registered manager was not aware of the incidents raised recorded by staff.

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 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
● People had their needs assessed prior to moving into the service to ensure their needs could be met. However, a new person had arrived the day before the inspection. The management team had not ensured that plans and any supplies needed were in place when the person arrived. This meant that this person did not have their glasses on and they had not received a wash or oral care on the evening prior to going to bed or in the morning of the inspection.

Adapting service, design, decoration to meet people's needs
● The building had been designed in a way that allowed people to move around freely. There were communal areas for people to use. However, the home was tired and tatty and in need of painting. Some ceilings, including bedrooms, had significant water staining from a leak. One relative said, "They have constant maintenance issues. They have had two incidents of flooding because the boilers were not properly maintained. The staff say the maintenance man is incompetent."
● The orientation board in the dining room of the unit supporting people living with dementia was not updated. The day and date was set to two days previous and the time was set to 1pm. This was not helpful in reorienting people during breakfast.
● Bedrooms were personalised in some cases. There were not enough shower rooms available. One which had been decorated nicely on the upstairs unit was out of action for up to six months as there was a lip on the shower tray preventing staff taking shower chairs in.
● Other shower rooms needed development so people could enjoy using them. These were often used as store rooms. One shower room had no lock on the door so that when a carer was supporting someone anyone could walk in.

These shortfalls were not identified through the provider's quality checks and this did not promote choice for people or ensure they were living in a suitably maintained environment. Therefore, this was a breach of Regulation 17 of the Health and Social Care Act (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.

● People had their capacity assessed for decisions relating to going out alone and the use of key pads on doors, and best interest decisions were recorded appropriately for these areas. However, some situations relating to people's needs required capacity assessments, best interests' decisions and plans to respond to these situations, but staff and the registered manager had not considered this. For example, when people were participating in close physical contact with each other.
● DoLS applications had been made relating to key pads, covert administration of medicines and going out alone. However, the registered manager was not aware that once authorised, these had an expiry date, and some had conditions that must be adhered to. The deputy manager had reapplied for a DoLS that had expired and was able to show that one condition had been partially met.

The home was not consistently applying the principles of the Mental Capacity Act 2005 which placed people at risk of unlawful restrictions. Therefore, this was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the food. One person said, "We do have a choice, I don't always want a hot meal, so I can just have sandwiches then."
● Dietary needs were known by staff and this included if people needed a pureed diet and thickened drinks.
● We saw staff supporting people to eat. However, one relative said, "[Person] eats pureed food now. They use a big dessert spoon and they put the food in really fast, sometimes I'm watching, and it makes me cringe, they don't give [person] time to swallow so I say something. They don't chat to her at all except to say 'come on, have you swallowed it yet?" We did not see this happen during the inspection however we shared this with the management team during the inspection.
●Weights were monitored, and action taken if people were noted to be losing weight and at risk.
● The dining experience could be improved. For example, on the day of inspection there was no choice of drinks on the ground floor unit, menus where not on tables, and condiments were not put out. Staff did not offer visual choices for people living with dementia or for those who were unable to communicate verbally.

Staff support: induction, training, skills and experience
● Staff had received training in subjects relevant to their role and they told us they felt they had enough knowledge to carry out their role.
● Staff said they felt supported and had one to one supervision meetings.

Staff working with other agencies to provide consistent, effective, timely care
● The team worked with the local authority to help ensure people received safe and effective care. An action plan was in place following a recent visit.

Supporting people to live healthier lives, access healthcare services and support
● People had regular access to health and social care professionals.
● We saw that when needed referrals were made to specialist healthcare teams, such as the tissue viability

nurse or the speech and language team.

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

Respecting and promoting people's privacy, dignity and independence

- Most staff were discreet when speaking to people or about people's needs. However, the registered manager was walking with someone and told us, "[Person] is apologising as they have messed themselves." This did not promote the person's privacy or dignity.
- Records were not always held securely so to promote confidentiality. We found several records outside bedroom doors, in the corridor throughout the day.
- Staff knocked on doors before entering. Most bedroom doors were open however, we were not able to determine if this was people's choice as it was not recorded in plans or notes.

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

- Staff did not always listen to people. One person was crying, and a staff member said, "She's always crying, she's got dementia." They said this in front of the person who cried louder and told the staff member, "I don't have that dementia, I know what I'm saying, you don't listen."
- Most interactions observed were positive. We heard and saw examples staff being attentive and reassuring to people. However, some people did not get the reassurance needed. For example, one person was asking for help at the dining table. Four staff stood in the dining room as the person repeatedly asked for support. When the person stood up, a staff member eventually went over to them. They wanted to use the toilet.
- Some staff engaged with people frequently and spent time with them chatting and laughing. One of the housekeepers was particularly responsive to people.

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

- People told us they were not always involved in planning and reviewing their care. One person said, "They wake me early between 5 & 6am, not my choice, I have no choice, they just appear. They wash me but they never ask me if I want a cup of tea so then I have to wait until 10.30 when they bring breakfast." Another person said, "Sometimes I go to bed before 5pm because they say 'we are so short of staff would you mind going to bed early?' so I do."
- Staff told us that they were aware they needed people's consent to care and that people's rights to make choices must be respected. However, some people we spoke with told us they had limited choice about what time they got up or went to bed.
- Staff said that people's rights had been upheld regarding which staff provided their care and support. For example, one person had refused to have care from staff of a specific nationality. This had been respected.
- Staff asked people before supporting them in most cases. For example, if they were ready to receive care

or if they would like a drink.

People were not treated with dignity and respect. Therefore, this was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014

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 deteriorated to 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

- People told us that they were not always happy with the care they received. One person said, "Today they changed my pad at 7.30am because it was wet through, soaking, my nightdress, the sheet everything. She changed my nightie and the sheet but didn't wash me, didn't have time just wiped my back with a wipe." Another person told us, "They never ask me if I want a shower, sometimes I will ask but they never come and ask me."
- A relative told us, "They (staff) keep saying they will cut her finger nails, but they don't, they don't have time to do things like that, but they say they will. I brought in the nail clippers." The person's finger nails were long and dirty. We found this to be the case for others too.
- We saw that one person who was new to the home had not received personal care as there were no toiletries to use and this had not been identified by care staff or the management team.
- Care plans covered all areas of people's needs but were basic. For example, where one person may refuse care and be at risk of self-neglect, the care plan stated, 'Record in daily notes, encouraged to wash, offered showers'. There was no reference to the person's preferences or choices to give staff clear guidance on how to prevent the risks of self-neglect.
- Plans did not prompt staff to act when supporting people living with dementia. One person's behaviours had escalated so staff asked for the mental health team for input. The person was prescribed paracetamol as needed for pain. The mental health team suggested that the person's behaviours indicated they may be experiencing pain so advised paracetamol to be given three or four times a day routinely and then re-assess. The mental health team re-visited nine days later and found the person was back to their old self and their behaviours had diminished.

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.

- Care plans set out how people needed to be supported with communication in some cases. However, no aids or tools were used. There were picture menus, but these were not used on the day of inspection.
- One staff member had a good idea about how to communicate with a person whose first language was not English. However, this had not been put into place.

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 gave us mixed views about if enjoyed the activities provided. One person said, "The activities lady is good for people with dementia, they like music and she arranges singing. She was a carer, now she is activities." Another person with impaired sight told us, "I would like to have a story read to me, but no one has any time. I used to have talking books, I loved that but now nothing. I have Alexa and used to listen to music but now it won't connect to the internet."
● There was a quiz taking place during the inspection and we saw the activities person sitting and doing a jigsaw with someone. The other activities person who was to provide activities for the other unit was absent on the day of inspection, so nothing was offered to people living upstairs.
● There was an activity poster displayed in corridors and some people were able to get out and about. One person said, "I can go into the town, I go to the pub and to the shops, they all know me in Tesco now. In the summer I can go to the community centre, and others can too, we like that."

End of life care and support
● End of life care was provided at the service.
● Care plans were in place to reflect people's practical and clinical needs. However, plans needed to be further developed to give staff guidance on how to support people in a way that promoted people's emotional wellbeing.

People did not always receive care that was personalised and met their needs. Care plans did not offer clear guidance for staff to deliver care in a person-centred way. Therefore, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Most people and relatives told us that they had made no complaints and were aware of the complaints process. However, one relative told us they had made a complaint, but they felt it was not dealt with well and they received no feedback.
● Another relative told us that a staff member had disclosed a concern to them and they felt the registered manager had not taken it seriously. We asked the registered manager about this and they told us they had spoken with those involved but had not documented it or put a management plan in place for the issue.
● Complaints we saw were recorded with outcomes and the registered manager had written feedback from the complainant to enable monitoring of their progress.

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 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

● The home has deteriorated in all areas. We found that there were multiples breaches of Regulation as a result of this inspection. We found concerns relating to infection control, dignity and respect, person centred care, unexplained injuries not recorded, investigated and reported, MCA and DoLS principles not being adhered to, the environment, the admission process and staffing concerns.

●The registered manager carried out audits to check that standards were to that expected and regulations were met. However, these audits and checks had not identified the issues we found as part of this inspection.

● The regional manager completed visits and checks to test performance. The most recent dated 26th January 2020, two days prior to our visit. The audit tool scored 84.46% with none of the concerns we found being identified. This demonstrates that this process was not effective.

● Where the homes quality assurance systems had identified shortfalls, action plans were implemented to address the areas. We found that this had been effective for some areas, such as, individual evacuation plans to be completed and fluid charts to be tallied, but other areas were not fully actioned. For example, involvement in care planning and confidentiality concerns.

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

● Meeting notes showed that some issues were discussed with staff. Mainly because of a recent visit from the local authority which had also identified shortfalls. However, the issues did not always get resolved after sharing them with staff. For example, mental capacity assessments to be completed for all decisions.

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

● There were opportunities for meetings for people and their relatives. There was an electronic tablet where people and visitors could add their feedback. Questionnaires were on the notice board for people to fill in and return. One relative said, "We noticed a feedback form in the room and there is a screen thing downstairs for feedback, but no one has asked me directly for feedback." A person told us, "We do have resident's meetings and they do an action list at the meeting. They try to get things done but money is the problem."

● Staff also told us that there were regular meetings and opportunities to speak with the registered

manager.

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

● People and relatives gave mixed views about the running of the home. People and relatives did not all know who the registered manager was. One person told us, "The manager is lovely." A relative told us, "I have no idea who the manager is. I would ask a carer if there was something wrong I think, they are quite helpful, most of them."

●Staff told us that the management team were very approachable and supportive. One staff member said, "The registered manager is always supportive, whether it is a work issue or a personal matter we take to her."

● However, we observed three instances where the registered manager appeared disinterested in what people were telling them. This related to a person who was sharing their account of a fall that they had witnessed, a relative speaking with them about a delay in dental care and a staff member with an idea for improving communication for someone.

Continuous learning and improving care

● Incidents and events were reviewed, and meetings discussed any learning as a result. However, not all incidents were added to the provider's system, so the management team were not always aware. This meant that analysis of these events could not always be relied upon.

● The areas we identified as part of the inspection were fed into the homes improvement plan to help them address them and this was sent to us the day after the inspection.

Working in partnership with others

● The management team worked with the local authority to address areas they found as needing development and training opportunities. However, the registered manager told us that they did not feel that the local authority's recent report was a fair reflection of the home. We found that the concerns identified by the local authority remained an issue on the day of this inspection.

There were several shortfalls with the management of the home and governance systems. Therefore, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | People did not receive care that met there needs and plans were not written in a person centred way. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect |
| Treatment of disease, disorder or injury | People were not treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent |
| Treatment of disease, disorder or injury | The principles of the Mental Capacity Act and Deprivation of Liberty Safeguards were not always adhered to. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | People's safety was not always promoted. |

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 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The leadership and governance in the home were inadequate and this placed people at risk of harm and of receiving poor care. |

**The enforcement action we took:**

We issued the service with a warning notice to set out what improvements where needed and we set a timescale for making these improvements.