Bath and North East Somerset Council

Charlton House Community Resource Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Charlton House Community Resource Centre is a residential care home providing regulated activities accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury to up to 30 people. The service provides support to people living with dementia, older and younger people and those living with a physical disability. At the time of our inspection there were 29 people using the service.

Charlton House Community Resource Centre is purpose built and provides accommodation over the first and second floors, the ground floor is primarily used as office space, and to facilitate training. Bedrooms are en-suite and additional communal bathrooms are located throughout the service. People have level access to a garden, communal lounges and dining spaces. The registered manager's office is located on the ground floor adjacent to reception.

People's experience of using this service and what we found
People sustained avoidable harm and were placed at increased risk of experiencing avoidable harm. When things went wrong, the provider failed to act consistently and implement measures to prevent a recurrence. People had experienced improper treatment and the provider failed to implement consistently robust responses to safeguarding concerns. Medicines were not always managed safely. People were at increased risk from the spread of infection because infection prevention and control measures were implemented inconsistently. After the inspection, we met with the provider and the local safeguarding team to discuss what actions they would take in response to our findings.

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 did not support this practice.

The provider failed to ensure they had oversight of care quality and safety, service level audits and checks were not used effectively to identify shortfalls, errors and omissions. The provider failed to ensure there was a consistently person-centred and empowering culture in the service. The provider failed to work in line with the duty of candour requirements when things went wrong. People told us they were well supported by permanent staff.

Activities provision was limited and we observed people watching television for extended periods of time. We found end of life care plans were of mixed quality, staff had recently worked to improve end of life care planning in the service and the process was ongoing. People's communication needs were assessed, however these needs were not always met. People told us they did not always have choice and control of their daily lives and not all care plans were personalised.

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 requires improvement (published 18 June 2022). At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns that a person with palliative care needs had not received the correct support, and that this had caused distress. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

In response to concerns we raised, the provider increased staffing levels and planned to implement a review of all areas of the service, including people's care plans and safeguarding concerns.

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

Enforcement and recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding, staffing and governance at this inspection.

In response to the more serious concerns we identified, we sought immediate assurances from the provider after our inspection.

We made one recommendation regarding the provider and registered manager's obligations in relation to the duty of candour.

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

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service 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**

Charlton House Community Resource Centre

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 team was made up of three inspectors, one bank inspector and one 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
Charlton House Community Resource Centre 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. Charlton House Community Resource Centre is a care home with 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed various records related to the running of the service, including care plans, audits and checks and staffing rotas. We spoke with eight people and four relatives. We observed care interactions and spoke with seven staff including the registered manager, assistant manager and care staff.

After the inspection
We continued to seek clarification around evidence gathered during the inspection. We raised a safeguarding alert with the local authority safeguarding team and reported our concerns to the contract and commissioning 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 requires improvement. At this inspection the rating has changed to inadequate. 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; Preventing and controlling infection

At our last inspection the provider had failed to mitigate risks in respect of fire safety and actions agreed in people's risk assessments. This was a breach of regulation 12(1) 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.

- The provider failed to protect people from avoidable harm and people were placed at increased risk of experiencing harm.
- One person's records stated the person was found with their window, "Wide open", a sheet for warmth and was, "Very cold to touch…" The person's temperature was recorded as 35°C. This placed the service user at increased and avoidable risk of hypothermia.
- The provider failed to ensure people were supported to access emergency medical support without delay. One person fell and trapped their arm, which was observed to be, "Purple" in colour. Staff failed to contact the GP until two hours later. Another person told staff they had experienced a stroke; staff recorded the person had arm weakness. Staff failed to seek emergency medical assistance until approximately seven hours after the stroke was first reported. On arrival to hospital, it was confirmed the person had experienced a stroke.
- When accidents and incidents occurred, the provider failed to implement measures to help prevent a recurrence. One person was found, "With their head caught between wires." The registered manager was unaware this incident occurred and no action was taken to prevent a recurrence. Photographs showed another person sustained extensive bruising to both shins. The registered manager believed the injuries resulted when the person knocked their shins on bed rails, however no action was taken to prevent a recurrence.
- People's sensor alarms were inexplicably turned off and their doors closed. During one day, a person experienced two unwitnessed falls, on both occasions the bedroom door was closed and falls sensor inexplicably turned off. The person was assessed as being at, "High risk of falls" and the sensor helped to mitigate this risk, by alerting staff who should support the person. The failure to ensure the sensor was switched on meant staff were not alerted to support the person with their transfers.
- The provider could not be assured people at risk of malnutrition and dehydration were receiving support they needed to improve their intake, and prevent deterioration. For example, for one person, no food or fluid records were completed for 27 or 28 October 2022. Records for 26 October 2022 showed the person had only

lunch, ice cream and 200 mls fluid. Another person was losing weight, records of food and fluid intake were incomplete and did not show they had received, or been offered, their nutritional drinks in line with their assessed needs. One staff member said, "We're so reliant on agency staff, and they're not proactive at filling in the paperwork."

● People were at increased risk from the spread of spread of infection.

● A communal bathroom was being used for the storage of staff belongings. We found shoes, a food safety hat and other items, such as bedding and a seat cushion, being stored in the same bathroom. This increased the risk of cross-contamination.

● Soiled items were not always stored in ways that helped to minimise the spread of infection. We found one bin in the communal bathroom was overflowing with soiled items.

● The provider failed to implement an enhanced cleaning procedure staff could access in the event of an infection outbreak.

● Corridors were used to store items such as wheelchairs and stand aids. Some of these had been labelled to inform staff they were clean to use. However, the date on some items was 23 September 2022, over a month prior to our inspection. This meant the provider could not be assured the items were still clean to use.

The provider failed to ensure people were protected from avoidable harm, placed people at increased risk of harm and did not implement measures effectively to mitigate risks. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection, the registered manager arranged for the removal of items from the communal bathroom.

● Visitors were supported to spend time with people in the service. Masks and hand sanitiser were provided at the entrance.

● In response to our concerns, the senior management team met with us and provided an action plan about what they would do to keep people safe. For example, introducing unannounced spot checks and attending staff handovers.

● At our last inspection we found people were at increased risk in the event of a fire because there was insufficient guidance in Personal Emergency Evacuation Plans (PEEPs) and fire drills were not taking place. At this inspection PEEPs we reviewed had been updated with additional information and fire drills were now taking place.

Systems and processes to safeguard people from the risk of abuse

● The provider failed to ensure people were consistently and robustly protected from abuse, and the risk of abuse. There was no oversight of safeguarding in the service. This meant the provider could not analyse information and identify potential themes and trends.

● Photographs showed one person with an imprint of a watch on their wrist, bruising and marks to their torso. The registered manager did not know who the victim was, or that the photographs existed. This meant no action was taken to investigate, or refer, the cause of the injuries.

● Potential indicators of abuse were not always reported to the local authority safeguarding team. For example, one record we reviewed showed a person had an unexplained bruise to their breast. No safeguarding alert was raised, this meant the local authority safeguarding team could not investigate the cause.

● On one occasion, records showed a person was found, "Very drowsy and sleepy." Staff identified the person, who was unable to mobilise, had been sat in their chair from 09:00am until 8:30pm, records did not confirm they had been supported with personal care. A similar incident occurred again when an ambulance

was delayed and the person was found, "Sitting in a chair of urine all night."
● The provider failed to implement processes that ensured potential safeguarding concerns were investigated effectively and immediately. One safeguarding investigation was delayed because the lead investigator felt, "Shocked from the distress of the situation" despite the investigator identifying in the same report a staff member was, "Mocking and taunting" a person and that other recordings were evident. This failure to act meant evidence was lost.
● The provider failed to implement robust, preventative measures in response to the same concerns. For example, staff used mobile phones to record people covertly, without their consent and mock a person with dementia. However, the provider allowed staff to continue bringing their mobile phones into work, while on duty for approximately two months after they were aware of the recordings. This meant the risk remained.
● When unknown individuals walked around the service, staff did not always check who they were. During one visit the recently appointed deputy manager observed, "Intruder alarm not activated. Back door found unlocked" and staff did not challenge the deputy manager, despite not knowing them. During a late-night visit as part of this inspection, two inspectors accessed the service without being asked for identification by staff until they reached the first floor.

People experienced improper treatment. Additionally, the provider failed to ensure people were consistently and effectively protected from the risk of abuse. 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

● After the inspection we alerted the local authority safeguarding team about our concerns, we attended a safeguarding meeting with the team and provider. At the meeting, the provider updated us about measures they had implemented in response to our concerns, including undertaking weekly audits to ensure potential safeguarding concerns were identified and reported.

Using medicines safely
● The provider failed to ensure medicines were managed safely.
● Protocols for 'as required' medicines (PRN) were not personalised and lacked detailed guidance for staff. For example, protocols for people who experienced periods of distress or anxiety, did not include guidance for staff about how they could support the person before medicating them. Records did not show any attempt by staff to try and avoid over-medication. Comments we reviewed included, "Sat in the lounge and was screaming, Lorazepam given" and, "Noisy until lunchtime, Diazepam given."
● People were at increased risk of receiving medicines incorrectly. Photographs linked to medicine administration records (MARs), and used to identify people during medicine administration, had not been dated. This meant staff could not be assured the pictures were a true likeness of people. This was of particular relevance because of the service's reliance on agency nurses. On day one of our inspection, we observed an agency nurse asking other staff to identify people when they were administering medicines.
● The provider could not be assured people's transdermal patches were being applied in line with manufacturer guidance. For example, people were prescribed patches that should not be reapplied to the same site for three to four weeks at a time. Records we reviewed showed patches were reapplied to the same site without the required rotation.
● Medicines were not always stored safely. Records did not show the temperature of the medicine room was being monitored. Additionally, although temperatures for refrigerated medicines were monitored, no action was taken when temperatures fell outside of the safe range. The failure to store medicines within safe temperature ranges can negatively impact their efficacy.
● The alarm for one medicine fridge was sounding during the first day of our inspection. The nurse on duty was unsure what to do about this and said they would report it to the management team. However, on the

second day, the alarm continued to sound.

The provider failed to ensure medicines were consistently managed and stored safely. This was a continued breach of regulation 12 Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After our inspection, the provider arranged for a clinically trained professional to review each person's documentation and support staff with the safe management of medicines.

Staffing and recruitment
● The provider failed to ensure there were sufficient numbers of suitably qualified staff to meet people's needs.
● The provider failed to ensure agency staff had moving and handling training required for their roles. On one occasion, a person fell and sustained a fracture. The staff member lifted the person into bed from the floor, without using equipment or additional staff support. An investigation found the staff member did not have practical moving and handling training. The provider failed to ensure subsequent agency staff working in the service had received practical moving and handling training.
● The registered manager did not have a systematic approach to determining the skills, competencies and numbers of staff required to meet people's needs. Instead, the registered manager confirmed staffing levels were based on, budget and the registered manager's experience.
● We observed there were not always sufficient numbers of staff to attend people. For example, when one person fell and required support from three staff, there were no additional staff to meet the needs of other people using their call bells. On another occasion in the dining area, we observed a person calling, "Nurse" for approximately 10 minutes before they were attended.
● People said there were times when they could not access the support they needed. Comments from people included, "Staff are good but not enough" and, "If I press the buzzer before lunch, it can be 15 mins to go to the loo." Comments from relatives included, "Staff are lovely but disorganised" and, "On certain days [it] seems two people [staff] on the whole floor."
● During our inspection, the provider arranged for staff from elsewhere in the organisation to work in the service. We were told this did not usually occur and was because, "CQC is here."
● The registered manager could not be assured staff had been recruited safely because they did not review and check recruitment files. One recruitment check recorded, "Could not find DBS records on files, there appears to be three processes." No action was taken to ensure the DBS records were viewed. DBS checks are important because they alert providers if an applicant has a criminal record and may be unsuited to working in care.

The provider failed to ensure there were sufficient numbers of suitably qualified staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In response to our concerns, the numbers of staff on each shift was increased until a full review of each person's needs was undertaken. The provider planned to implement a systematic way of determining staffing levels to ensure care was delivered in line with people's assessed needs.
● People told us permanent staff were kind to them. Comments from people included, "Generally the staff are quite nice and helpful" and, "Regular staff are good."
● The provider told us they planned to initiate a 'champion' system whereby certain staff were supported to attain enhanced understanding of specific areas, including health and safety and safeguarding. These staff could then support colleagues to improve safety in the service.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- Consent to care had not always been sought in line with guidance and the law.
- When people lacked the capacity to make a specific decision, there was no documentation to show how best interest decisions had been made.
- Some capacity assessments had been filled in incorrectly. For example, we looked at the assessment for one person around meeting their hygiene needs. It was documented the person lacked capacity to make the specific decision for themselves, but staff had documented, "In [person's name] best interests, informed consent was gained." If the person lacked mental capacity in relation to this specific decision, they could not give informed consent.
- In another person's care plan, it was recorded they lacked capacity to make a decision about the use of a sensor alarm. Although information was recorded about why staff believed the sensor should be used, there was no information documented to show that other, less restrictive options, had been considered or if other people and professionals had been involved with the decision making.
- When required, the registered manager made DoLS applications to the local authority.
- We found one best interest decision in relation to a person receiving their medicines covertly, was undertaken in line with guidance and the law. The documentation was clear, showing who was involved with the process and how the decision had been made.
- After our inspection, the provider told us all staff had been booked to attend face-to-face MCA training and documentation would be reviewed as part of a larger, full review of all care plans in the service.

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. At this inspection the rating 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

- People told us they did not always have a choice and control in relation to their daily living. Comments from people included, "There is no choice, sometimes dessert sometimes no, yesterday sponge and custard, hospital food was better and got a choice," and, "I am avoiding TV it's all miserable. The staff turn it on and then leave it and I can't turn it off."
- Care plans were in place and informed staff about people's needs. However, not all plans were personalised to inform staff about people's choices and preferences. For example, in some people's nutritional plans there was information recorded about things people liked to eat and drink and the type of cutlery and crockery they used, but this was inconsistent.
- The quality of wound care plans was inconsistent. For example, wound measurement tools were not always used and this meant staff could not be sure if wounds were improving or deteriorating. We discussed this with the deputy manager who confirmed they were in the process of reviewing wound care documentation and training for staff.

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.

- Care plans described people's communication needs. This included details such as whether people wore hearing aids or glasses.
- Some people had more complex communication needs, and the service used picture boards to help people express themselves. Staff used other methods to support people with their communication. For example, voice activated alarms for people who were unable to press the call bell. However, when we looked at these, one was not working properly. The staff on duty were not aware of this until we informed them. On another occasion, the device had been set to vibrate, this meant staff would not hear the person if they called.

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

- During our inspection, we observed most people sitting and watching television for extended periods of time. The activities board was out of date and not updated during our inspection. Activities on offer included board games, a quiz and nail care. The activities schedule showed most activities were offered in the

morning, one person said, "If get up late, I miss activities."
● Comments about activities provision included, "I watch TV, mostly sleep. I have visitors, the last couple of weeks the cleric has come in" and, ""They take her up for activities, I think [staff member] gets her, she gets out of her room most days."
● People were supported to received visitors and we observed relatives visiting during our inspection.

End of life care and support
● The quality of end of life care plans was inconsistent.
● Care plans that had not been recently reviewed lacked detail and guidance for staff about people's preferences. We reviewed recently updated end of life plans and found these were detailed, with contributions from people and their families.
● New support documentation had been introduced to ensure all aspects of people's care was considered at each intervention, such as checking the person's mouth was clean and moist and assessing for any pain or distress.
● A member of staff said, "I provided some palliative care to [name]. The GP was involved, and the local hospice will support if we need them. It's obviously a different type of care. I've started to look at end of life planning across the home now. I do feel everyone should have that in place."

Improving care quality in response to complaints or concerns
● Complaints were logged and responded to. Records we reviewed showed action had been taken, for example relevant information was shared at staff team meetings.
● People we spoke with were not always clear about who they would report concerns to. Comments from people included, "I don't know who I would talk to" and, "I would talk to the assistant manager if I had a problem."

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to establish and operate governance systems to identify shortfalls in the quality of care provision and safety and ensure there was a contemporaneous record of care delivery in respect of the delivery of care. This was a breach of regulation 17 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 governance framework was not used effectively and had failed to identify the shortfalls we found during our inspection.
- Service level checks and audits we reviewed were overwhelmingly incomplete or blank, they had not been used to monitor the safety and quality of care provision in the service.
- When shortfalls were identified, the provider failed to act and drive improvement. For example, one entry recorded, "Not all risks are being covered in the care plan for residents" and, "TBD" [to be determined] was recorded in relation to the person responsible for addressing this. Another audit identified there were insufficient staff to meet people's needs. However, audits did not include information about actions taken to rectify these shortfalls.
- There was no provider level oversight of the service. For example, in relation to people's safety and safeguarding systems, one audit recorded, "There are no further checks being completed at senior management level." Additionally, the provider was not always aware of significant events that occurred, including when one person trapped their head in wires and another was found borderline hypothermic. This meant the provider could not be assured people were receiving safe, good quality care, or that the registered manager was receiving the right support to improve the quality of care provision.
- The registered manager's office was located on the ground-floor, where people were not accommodated. This did not support the registered manager to have oversight of the day to day running of the service, or identify and address the widespread and significant shortfalls we found during our inspection.
- The provider failed to ensure records were stored securely. We observed people's care plans unattended in the lounge. This meant people's confidential information was accessible to anyone.
- The provider failed to identify the service's mobile phone contained photographs of people, including of their intimate areas. While the photographs were taken to document wounds or injuries, some were over a

year old and should have been deleted to protect people's dignity and privacy.

The provider failed to establish and operate governance systems effectively, to accurately measure the safety and quality of care provision, and drive improvement. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After our inspection, the provider submitted an action plan detailing how they would review and monitor all documentation in place. The provider confirmed they planned to implement a new governance framework and electronic care planning system.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager and provider were aware of their responsibility to act openly and transparently when things went wrong. However, when notifiable safety incidents occurred, they did not always act in line with the regulation and issue a written apology.

We recommend the provider review the regulation, and associated guidance, to ensure they respond in line with their obligations going forward.

At our last inspection the provider had failed to notify CQC about specific events which took place at the service. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

● At this inspection we found enough improvement had been made and the provider was no longer in breach of this regulation. Notifications were submitted as required and had been submitted in relation to events we reported to the provider in relation to this inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
● The culture was not always person-centred and positive. This was reflected when some staff used mobile phones to record people covertly, without their consent and mocked a person with dementia.
● Care interactions were not always positive. For example, we observed one staff member supporting a person to eat and then pulling their mask down to take bites of their own lunch in between. We also observed caring interactions, for example one staff member handing over information about one person's interests and prompting another person to eat independently.
● People and relatives told us care provision was not always person-centred and empowering. For example, one relative told us a person was wearing their clothes from yesterday and we saw a report detailing a similar incident had occurred when two people were left in their day clothes overnight. One relative said, "[Person] sometimes feels staff are shoving medications at him without warning."
● Permanent staff we spoke with knew people well and were able provide detailed information about how they supported people. One staff member said, "It is my priority to give people their choices; little things like someone who liked to go to church on a Sunday, as [they got unwell] I asked if they wanted to watch the [service] on TV."
● Staff worked with external professionals, for example people were supported to attend audiology appointments and opticians. One person said, "The physios [physiotherapists] do come."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
● The provider had recently facilitated a meeting with relatives to discuss any concerns. The registered

manager said they operated an open-door policy so people could access them when they wished.
● The provider worked with a local group and offered young people with a learning disability the opportunity to visit and work in the service.
● Adjustments were made to meet individual religious requirements, for example providing staff with access to a prayer room.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People experienced improper treatment. Additionally, the provider failed to ensure people were consistently and effectively protected from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably qualified staff to meet people's needs.

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
Treatment of disease, disorder or injury	The provider failed to ensure people were protected from avoidable harm, placed people at increased risk of harm and did not implement measures effectively to mitigate risks. The provider failed to ensure medicines were consistently managed and stored safely.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to establish and operate governance systems effectively, to accurately measure the safety and quality of care provision, and drive improvement.

The enforcement action we took:

Warning Notice