Northfield Care Limited

Northfield House

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Northfield House is a residential care home providing personal and nursing care to up to 25 people. The service provides support to older people, many of whom live with dementia. At the time of our inspection there were 22 people using the service. People are accommodated in one adapted building and there is access to a decking area and garden.

People's experience of using this service and what we found
People's risks had not always been fully assessed. Risk management actions had not always been clearly developed to reduce or mitigate people's risks. People's risks had not always been reviewed when their health or circumstances had altered. This included risks associated with falls, prolonged immobility, seizures, the use of some medicines and evacuation in the event of a fire. In this respect, lessons about the management of these types of risks had not been fully learnt.

The provider had ensured all staff were familiar with the service's post falls protocol which included what to do if the fall included a head injury. Senior staff who administered people's medicines were aware of who was prescribed an anti-coagulant and aware of the increased risks of bleeding for these people, post fall. Not all staff were aware of the service's seizure management protocol. Action had been taken to more closely monitor moving and handling practices and to ensure staff were trained and competent in this practice.

People's medicines had not been effectively managed. People had not always received their medicines as prescribed. The processes for ensuring medicines errors were identified and addressed had not been operated effectively. This put people at risk of the impact caused from medicine errors.

Care and treatment plans had not always been developed to provide staff and other health care professional involved, clear information about people's needs and how these should be met. This put people at risk of not receiving the care and support they required to protect them from harm and to meet their assessed needs.

People did not always receive the support they required to eat and drink. In one observed case a relevant care plan, providing staff with information on how to support the person in this area, was not followed in practice. In another case the person's needs in relation to eating and drinking had not been assessed and a plan of care not developed.

The provider's monitoring processes were not fully and effectively implemented. The areas where we found shortfalls had not been sufficiently monitored by the provider. This meant these shortfalls had not been fully identified and action not taken to ensure people received safe and appropriate care.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Despite challenges in recruiting staff the provider had taken action to ensure there were enough suitably skilled and knowledgeable staff to meet people's needs. Staff were provided with appropriate training and support, relevant to their role.

People had access to reviews by their GP and other services such as chiropody, optical reviews and dental support as required.

Arrangements were in place to keep the environment people lived in clean and safe.

Complaints and concerns were listened to and action taken to address these and to learn from these.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability.

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 good (published 2 July 2021).

Why we inspected
We received concerns in relation to post falls management and the management of prescribed anti-coagulants and the moving and handling of some people. As a result, we undertook a focused inspection to review the key questions of safe, effective 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 where these key questions were inspected to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
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 the assessment and management of people's health and care risks and the management of medicines at this inspection.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below

Northfield House

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
One inspector and an Expert by Experience carried out this inspection. 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
Northfield House 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. Northfield House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

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 including information from the provider about events involving people. This included notification about serious injuries, abuse and deaths. We sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care and services provided to them. We spoke with two sets of relatives who were visiting and gained the views of a further five relatives by telephone. 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 spoke with five care staff and a member of the housekeeping staff. We spoke with the maintenance person, administrator, registered manager and nominated individual. We also spoke with a visiting health care professional.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed seven people's care records and nine people's medicine administration records. We reviewed records relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. We reviewed one staff member's recruitment file and the service's staff training record. We reviewed records relating to the management of the service which included a selection of audits, to include the provider's monitoring visit records, complaints investigation records and the service development plan. We reviewed maintenance records, contractors' inspection and servicing records and records relating to fire safety, including and people's personal emergency evacuation plans.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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.

Using medicines safely

● People had not always received their medicines as prescribed. Some medicines had not been administered because staff had believed them to be out of stock. Staff had recorded these medicines as 'out of stock' on people's medicines administration record (MAR). The fact that medicines were believed to be 'out of stock' had not been reported or addressed by the staff. On the eighth day of one person not receiving their prescribed medicine, a member of staff questioned this with the registered manager. Once alerted the registered manager found the additional stock of medicine, in the main medicines stock cupboard and on a shelf in the main medicines room. It had been correctly stored for the duration of time staff thought it was out of stock.

● Pain relief medicines had not always been administered as prescribed. Staff had forgotten to administer a long acting pain relief on the day it was due. This omission was not identified until four days later when the medicine was correctly administered. Shorter acting pain relief had also not been administered for two consecutive doses because staff believed the medicine to be out of stock when this had not been the case.

● Prescribed medicines had sometimes been incorrectly administered because staff had misread the administration instruction on the MAR. People had received double the prescribed dose, in one example, for two days and in another example, for one day.

● A medicine had been incorrectly stored. A higher dose of one person's medicine had been placed in the packaging for the lower dose of the same medicine. The error had been observed but not reported.

People had not received their medicines as prescribed and they had not been protected from medicine errors which may impact on their health. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately during the inspection, taking some action to reduce further medicine errors.

● There had been no lasting impact on people from the above omissions and errors.

Assessing risk, safety monitoring and management

● Following people's admission to the care home the provider's risk assessment processes had not always been completed. This meant risks associated with people's health and safety had not always been fully assessed. Care plans had not always been developed to give staff clear guidance on the actions they must take to reduce or mitigate people's risks. This included risks associated with poor mobility, prolonged bed rest, falls, seizures, anti-coagulant medicines and evacuation in the event of a fire.

● People's risks assessments and risk related care plans had not always been reviewed to ensure the actions

adopted to manage these risks remained relevant and effective. This was seen following a change in people's health and abilities or following an event which required assessment by paramedics and further medical investigation. For example, post fall or following a health-related event.

● Appropriate wound care processes had not been followed. A wound had not been reported to an appropriate health care professional for assessment. Wound care had been provided without prior assessment or without the development of a treatment plan by a suitably qualified health care professional. This practice puts people with wounds at risk of receiving inappropriate or unsafe treatment.

People were at risk of not receiving the care and treatment they required to reduce or mitigate risks associated with their health and safety. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Learning had not been fully taken from events which had impacted on people's health. This was seen in the lack of effective risk assessing and care planning for risks associated with falls, seizures and the use of anti-coagulants.

● A seizure protocol was in place but not all staff were aware of this.

● Action had been taken to ensure staff were aware of the service's post falls protocol. This gave staff guidance on the action to take post fall and post fall when a head injury was included. It also provided guidance for staff on the action to take post fall for people prescribed an anti-coagulant and who were at increased risk of internal bleeding following a fall.

Staffing and recruitment

● The provider had experienced significant challenges in recruiting suitable staff. They had however, organised their staffing needs by using agency care staff. Permanent staff had been flexible in how they worked. At the time of the inspection there were enough staff to meet people's needs and to support the overall running of the care home.

● When possible, the same agency staff were used to reduce the impact on people from having too many unfamiliar staff. Some agency staff had worked at Northfield House for many months and knew people's needs well.

● An ongoing recruitment campaign had been successful in identifying prospective new staff who, once their recruitment checks had been completed, were due to start work. The provider anticipated this would ease the current burden of such a high dependency on agency staff.

● A member of staff recently recruited by the provider had successfully completed the recruitment process which, included a check on their employment history, reasons for leaving and employment references. It also included checks through the Disclosure and Barring Service (DBS). These provided information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● The provider took steps to reassure themselves that the agency they used for obtaining staff completed appropriate employment checks and induction training.

Systems and processes to safeguard people from the risk of abuse

● All staff working in the care home completed safeguarding training and were aware of the provider's policies and procedures for safeguarding people.

● The registered manager and provider adhered to the local authority's safeguarding protocols. This included sharing relevant information with the local authority's safeguarding team and other external agencies who have safeguarding responsibilities; police and CQC.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- There were no visiting restrictions and people's relatives and friends could visit as they wished to. The only exception to this would be during a period of infection in the care home when the registered manager would adhere to guidance given by the local health protection team on visitors to the care home.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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; Staff working with other agencies to provide consistent, effective, timely care

- People's health and care needs, including those more specific and common to older people living with a cognitive impairment, had not always been fully assessed on admission. These included needs associated with moving and handling, poor or no mobility, eating and drinking, personal care, skin care, continence, pain, emotional and social needs and religious preference.
- People's needs had not always been re-assessed and their relevant care and treatment plan not always reviewed, when their needs had altered. This included following a fall, decreased mobility or prolonged immobility, refusal of food and drink and pain.
- The provider's adopted care records system provided staff with nationally recognised assessment and care planning tools, as well as a process for reviewing both, in accordance with best practice guidelines. This was not always completed or fully maintained by the staff.

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

- People did not always receive the support they needed to eat and drink. We observed two people not engaged with their food at lunch time. One person's care plan stated they required supervision and prompting to eat. There was no prompting or supervision provided by the staff and the person did not eat any lunch. The same was observed for one other person.
- On inspecting the daily care records these missed meals were not recorded by the care staff and no verbal report had been given to the senior carer on duty. This meant an accurate account of these people's food intake, for that day, had not been captured. Thereby an opportunity to ensure further choices of food or increased snacks were provided during the afternoon had been missed.
- Another person's daily care records frequently recorded their refusal of food at lunch time. As there had been no review of these and initial assessment and care planning had not been completed in relation to this daily activity, there were no planned care actions to address this. We also observed this person's lunch to be placed on a bedside table which was not within the person's reach.
- Another person's nutritional care plan stated they could eat independently but we found their needs had altered. We observed one agency member of staff helping them to eat their food and to drink. The agency member of staff told us they had worked at the care home for some time; they were familiar with the change in this person's needs. However, a less familiar member of staff may potentially not be aware of the support this person now required, to ensure their nutritional and hydration needs were met. This is because the care actions recorded in the relevant care records had not been reviewed and amended to reflect the person's current needs.

People were at risk of not receiving appropriate person-centred care and treatment which is based on an assessment of their needs and preferences and which is designed and implemented in accordance with best practice guidelines. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● All staff newly employed by the provider completed induction training which included an introduction to some of the provider's key policies and procedures. Staff completed online and face to face training which included modules from the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● When an agency member of staff started work at the care home the provider was given information about the staff member's training provided by the agency. We saw this was basic training in line with modules from the care certificate.

● Just prior to the inspection the provider had requested evidence from the care agency that staff were up to date in safe moving and handling training. Depending on the result of that, if staff required update training the provider would ensure this was completed. Once working at the care home, the provider ensured these staff completed training alongside their own staff.

● Staff employed by the care home completed supervision sessions with the registered manager. These were a mixture of one to one supervision meetings to discuss individual performance and training needs. Group supervision sessions included the provider's own staff and agency staff and was an opportunity to discuss specific areas of care and best practice as well as the provider's policies, procedures and expectations. Staff annual appraisals were due to take place in September 2022.

● Staffs' skills, experience and familiarity with people's needs was taken into consideration when organising the staffing rosters. A senior carer or medicines trained member of staff was always on duty. This ensured medicines were administered by staff who were trained to do this.

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

● People had access to a GP when needed. A GP visited the care home regularly and reviewed people's health needs, medicines and DNACPR (do not attempt cardiopulmonary resuscitation) decisions.

● People had access to regular chiropody, but the last planned visit had to be cancelled due to COVID. A new date had been organised for early September 2022.

● Professionals from the emergency services such as paramedics and NHS Rapid Response teams were used when people required urgent medical support.

● Staff supported people to attend hospital, dental or optical appointments where the person's relative was unable to do this or where a person had no support to do this. Annual optical reviews were organised and completed in the care home by a visiting optical service. Dental care was sourced as required.

● People enjoyed a weekly exercise to music session with an external fitness instructor, which helped to support people's ongoing mobility and movement as well as their mental wellbeing as it was also a popular social activity.

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

● The environment inside the care home supported the needs of older people and those who lived with dementia. Signage was prominent for example, for the toilets which helped people locate these independently.

● Bathrooms and toilets had been adapted to support safer use and access for people with limited mobility, for example, with grab handles, raised toilet seats and bath hoists.

● People who were assessed as unsafe to leave the care home independently had the freedom to walk with purpose and without restriction within safe areas. This was achieved using keypads to areas which were potentially not safe, such as stairwells and the main reception area where visitors were coming in and out of the front door.
● A garden could be accessed by the main lounge area had been designed to enable people, including those in a wheelchair, safe access to an outside space. People had a choice of areas to sit as well as visual stimulation through the use of colour and various ornaments used in the garden.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff sought people's consent prior to delivering care.
● Where appropriate people's mental capacity was assessed regarding decisions which needed to be made about their care and treatment.
● Where people had been assessed as not having mental capacity to make independent decisions about their care and treatment, these decisions were made in their best interests, by appropriate person's. This included the person's GP, other involved health and social care professionals and the staff. People's legal representatives were also consulted.
● DoLS applications were appropriately made by the registered manager who kept a record of when these were authorised and due to expire so appropriate new applications could be applied for.
● At the time of the inspection there were no conditions to the DoLS which had been authorised.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's quality monitoring processes had not been effective in identifying the shortfalls we found during this inspection.
- Monthly auditing of medicine administration records (MARs) including the overall management of people's medicines, had not been effective in identifying that people's medicines had not always been administered as prescribed. It had not identified that medicine errors were not being reported by staff and were not getting addressed.
- Monitoring processes had not effectively identified the shortfalls we identified in the assessment, planning and review of people's risks and care needs.
- The provider's monitoring processes had not identified a shortfall in wound management process which had resulted in the delay of appropriate referral to a suitably qualified health care professional for assessment and treatment.
- People's daily care records, wound management record, risk assessments and care plans had not been consistently maintained. Therefore, the requirement to maintain accurate records about people's care and treatment had not been met.

The provider's quality monitoring processes had not been effective in identifying shortfalls in the assessment, planning and reviewing of people's health care and safety needs. It had not identified that people's medicines had not been administered as prescribed and that the assessment and treatment of a wound had not followed best practice guidelines. This puts people at risk of inappropriate and unsafe care and treatment due to a lack of effective quality monitoring and governance arrangements. This was a breach of regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's daily care records, wound management record, risk assessments and care plans had not been consistently maintained. Therefore, the requirement to maintain accurate records about people's care and treatment had not been met. This meant a clear audit of the care and treatment required and provided to people, for staff and visiting professionals' reference, was not available.

This puts people at risk of receiving inappropriate and unsafe care and treatment due to a lack of accurate and up to date information about people's care and treatment. This was a breach of regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had been newly registered with the CQC nine days prior to this inspection and had been managing the service since May 2022. The service had experienced significant challenges during this time, which had impacted on the registered manager's ability to fully complete their monitoring tasks. For example, the recruitment of new staff into key positions.
● Audits relating to health and safety, infection control, maintenance and the environment, staff training and accidents and incidents had been completed, last in late July and early August 2022. Actions from these monthly audits were added to the service's ongoing development plan. Progress on the completion of the development was monitored by the provider and discussed with the registered manager.
● A decision had been made to return the weekly auditing of people's medication administration records (MARs), back to monthly auditing following an improvement in the completion of these records. However, as the last audit was completed in the middle of July 2022, this had not captured the shortfalls found during the inspection in relation to medicines. The registered manager informed us medicines would be audited more frequently following the inspection.
● Both the provider and registered manager had already identified a need to alter the format of the care records audit; making it more user friendly and relevant to the requirements of Northfield House. Training in the auditing of care plans and other associated records was needed for some staff so a new audit had not been implemented by the time of the inspection. The registered manager had been relying on their senior care staff to maintain these records without introducing any other form of check to ensure this was happening.
● The provider and registered manager were aware of their regulatory responsibilities, which included ensuring CQC was notified of events involving people who used the service, such as serious injuries, abuse and deaths.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Despite the challenges the registered manager had developed an open and inclusive culture where permanent and agency staff were working alongside each other as one team. Staff employed by the provider, as well as the agency staff told us they felt supported and able to approach the registered manager for advice and support. Staff told us the registered manager had always been willing to help them with their tasks when this had been necessary.
● Relatives told us they felt there had been an improvement in the management of the service despite the staffing challenges. They told us they were kept informed about their relatives' care and their concerns were listened to and addressed.
● Despite the shortfalls identified during the inspection we also observed good practices which supported people's individual needs and preferences and a caring approach towards people was observed.

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
● Both the provider and the registered manager understood their responsibility to be open and honest when things went wrong.
● One relative told us they had been informed by the registered manager of poor moving and handling practices involving their relative. This had been observed when the registered manager had reviewed footage from the CCTV installed in the communal areas. The relative had been informed of the action taken in response to this; they had reported this to the local authority's safeguarding team and the agency staff stopped from working in the care home. The relative told us they were "more than impressed by this action."

● People or their representatives had not yet been informed about the medicines' administration shortfalls as these were identified during the inspection.

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

● The provider sought feedback from relatives and staff as part of their monthly provider audit. Records of these audits recorded feedback from people's relatives and staff during the provider's monthly monitoring visits.

● Satisfaction questionnaires had been sent to people's relatives and representatives in May 2022; 29 had been sent and six had been returned in June 2022. These showed positive results for all areas of requested feedback.

● People were also asked for their feedback during the provider's monthly visits. In doing this the provider was aware of some people's limited cognitive ability to engage in this process. However, where this was the case, the provider used this as an opportunity to review people's levels of wellbeing, which was recorded as part of the audit.

● Feedback and ideas for improvement were sought from staff during these visits and in 'team talks' attended by the provider.

● Where feedback had been provided by people, relatives and staff the provider had acted on this, where it was safe and practicable to do so, to make improvements to the service. This had included for example, seeking a quote to connect the front doorbell to the call bell system so this could be better heard and responded to by the staff. The provider had also employed administrative support, and this was making improvements to the timeliness in responding to, the front doorbell, telephone calls and emails.

Continuous learning and improving care

● Improvements made following previous inspections had been maintained. This included the completion of fire drills and evacuation practice, kitchen management, staff culture and infection, prevention and control arrangements.

Working in partnership with others

● The registered manager worked with commissioners of care to ensure people could access the support of the care home when needed. For example, they completed pre-admission assessments of need soon after receiving a referral for care.

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 People were at risk of not receiving appropriate person-centred care and treatment which is based on an assessment of their needs and preferences and which is designed and implemented in accordance with best practice guidelines. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality monitoring processes had not been effective in identifying shortfalls in the assessment, planning and reviewing of people's health and care needs and associated risks. It had not identified that people's medicines had not been administered as prescribed and that the assessment and treatment of a wound had not followed best practice guidelines. This puts people at risk of inappropriate and unsafe care and treatment due to a lack of effective quality monitoring and governance arrangements. Regulation 17 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not received their medicines as prescribed. The service did not have effective processes in place to protect people from medicine errors. Risks associated with people's health and safety had not always been assessed. Actions required to reduce or mitigate risks had not always been formally determined and, in some cases, not fully or appropriately implemented. This puts people at risk of not receiving the care they need to reduce or mitigate risks which may impact on their health and safety. Regulation 12 (1)

The enforcement action we took:

We issued a warning notice on 8 September 2022.