Mrs Helen Judith Walsh

# The White House Falmouth

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

# Summary of findings

## Overall summary

About the service
The White House Falmouth is registered to provide care and support for up to 17 older people. At the time of the inspection the service was supporting 16 people.

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

People told us they felt safe and that their staff were, "as good as gold". However, we found the provider was not giving effective leadership and that this had impacted on the service's performance.

The service was short staffed and the dedicated staff team were regularly working additional and sometimes excessive hours each week to ensure people's need were met. Although rotas were difficult to understand, staff assured us minimum staffing levels had been consistently achieved.

Necessary pre employment checks had not been completed for recently recruited staff. The provider was unable to demonstrate staff training had been regularly updated and senior members of staff had not received regular supervision.

Risk in relation to people's support needs, the environment and fire safety, had not been managed appropriately. Staff had not been provided with accurate guidance on the management of risks.

Medicines administration records had been accurately completed and staff understood how to support people with their medicines. Facilities for the storage of medicines that require additional security were insufficient and medicines administration on the use of as required medications lacked guidance.

The provider did not understand the requirements of the Mental Capacity Act and people's capacity to make specific decisions had not been appropriately assessed.

Care plans were inaccurate and did not reflect people's current needs. Although staff understood people's needs the records available did not provide sufficient guidance to enable new or agency staff to support people. Information about people's communication needs was also inaccurate and staff were unable to locate identified communication tools.

The provider did not have systems in place to ensure complaints and concerns reported were investigated.

The personal circumstances of the provider had impacted on their ability to give effective leadership and support to the staff team. Quality assurance systems were ineffective, the service records were disorganised, and information was difficult to access. Necessary notifications had not been submitted to the commission.

People and relatives were complimentary of the staff team and the culture of the service was caring and

compassionate. Staff responded promptly to requests for support and relatives told us, "[The staff] have been very good, very caring".

Staff had a good understanding of infection prevention and control protocols and current COVID-19 guidance was being followed.
People were complimentary of the food, and kitchen staff had a good understanding of people's likes and needs.

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 the service was Good (Published 23 October 2019). At this inspection we found the service's performance had deteriorated to requires improvement and breaches of the regulations were identified.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and the accuracy of care planning in the service. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive and well-led.
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.

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 Person centred care, Need for consent, Safe care and treatment, Premises and equipment, Good governance, Staffing and Fitness of staff employed at this inspection.

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

Follow up
We will meet with the provider 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. 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 always 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 responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# The White House Falmouth

**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.

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

Inspection team
The inspection was carried out by two adult social care inspectors. Two inspectors were present on the first day of the inspection and one inspector was present during the second inspection day.

Service and service type
The White House Falmouth is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This provider is not required to have a registered manager to oversee the delivery of regulated activities at this location and the provider is 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 were no managers in post and the provider was responsible for the day to day operation of the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed the information we had received about the service since the last inspection as part of the planning process. 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.

During the inspection
We met and spoke with nine people who lived at the service and three relatives who visited regularly. We also spoke with six care staff and the provider about the service's current performance.

We looked at records relating to people's care. This included four care plans, medicine administration records (MARs), three staff files and records relating to the management of the service including staffing rotas, quality assurance audits and safety documentation. We also sought feedback from two health and social care professionals about the service's current performance.

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 Good. At this inspection this key question 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.

Staffing and recruitment

● The service was short staffed and the small, dedicated staff team were regularly working additional hours to ensure safe staffing levels were achieved. Staff comments included, "My only concern is staffing" and "Staffing levels, we could do with more as there are real pinch points in the day, for example first thing in morning, lunch, after lunch and teatime. Especially with people needing personal care".

● The provider recognised the service was short staffed and agency staff had been used to ensure safe staffing levels were consistently achieved. The provider had also completed care shifts when necessary to ensure safe staffing levels were achieved. Professionals told us, "[The staff] are always saying to [visiting professionals] that they do not have adequate staffing and they often work really long shifts and appear tired."

● The provider had identified that current vacancies equated to around 80 hours per week and that ideally an additional four part time staff would be recruited. Although the provider had been advertising these roles, recruitment was difficult across the sector.

● Rotas were difficult to interpret, and it was not possible during the second site visit to establish which staff had completed which shifts in the previous week. However, staff were confident planned staffing levels had been achieved and told us, "Three staff in the day is enough. We have quite a good shift plan and there is never not enough staff on shift. It just means staff have to do a few extra hours".

●Relatives recognised the current staffing situation was challenging and one relative told us, "I never feel they are understaffed, they are busy but there is always time for the residents." Professionals reported that staffing pressures had sometimes impacted on the quality of care people received as staff did not have time to support people to remain as independent as possible.

● The rotas showed some staff members were regularly working excessive hours. In one week, one staff member had been scheduled to complete 72- daytime hours and 48 hours of sleep in shifts. Working excessive hours with limited opportunities for rest increases the risk people will be harmed. As fatigued staff are likely to react slower, become less attentive and are more prone to errors.

The provider had failed to ensure enough staff were available to meet people's support needs. This forms part of the breach of the requirements of regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service's recruitment practices were unsafe. The provider was unable to demonstrate necessary checks, including DBS checks, had been completed to ensure recently recruited staff were suitable for employment in the care sector.

The provider had not completed necessary pre-employment checks for all staff. This was a breach of the requirements of regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risk in relation to people's care needs had not been identified and mitigated.
● Risks in relation to falls and mobility needs had not been appropriately assessed and updated when needs changed. One person's falls risk assessment indicated they mobilised with an aid and their care plan said they regularly accessed the service's lounge. These documents had been completed in 2019 and at the time of inspection we found this person was unable to mobilise independently, unable to access the lounge and was being cared for in bed.
● Visiting professionals had identified risks in relation to one person's skin integrity. As a result additional guidance was provided and regular repositioning and additional recording in relation to skin health had been introduced. However, these records had not been accurately completed. When staff had found bruising on this person this information had not been recorded in the skin health notes.
● Risks in relation to people's weight loss had not been effectively managed. The service had systems in place to monitor people's weight. However, where concerns in relation to weight loss were identified there was limited evidence of appropriate referrals to professionals. Where guidance had been received and more calorific foods were being provided this information had not been documented in people's care plans.
● Cleaning materials were not stored securely. A cupboard whose door was labelled with a "fire door keep locked" was open and unsecured. This cupboard contained a variety of COSHH cleaning materials that people living with dementia could access independently. This meant people were exposed to significant risk of harm.
● On the first day of our inspection the fire door to the service's laundry room was physically tied open so that it could not close automatically in the event of a fire. This fire door was also labelled, "Fire door keep locked". Laundry areas represent a significant fire risk and by tying this door open and failing to secure other fire doors, people living in the service were exposed to significant risk of harm.
● No personal emergency evacuation plans (PEEPs) were available detailing the support each person would require in the event of an emergency evacuation.

The provider had failed to manage risks both in relation to people's care needs and the environment of the service. This unnecessarily exposed people to risk of harm and contributed to a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Lifting equipment had been appropriately serviced and necessary testing of the fire alarm and emergency lighting systems completed.

Learning lessons when things go wrong
● The provider did not have systems in place to ensure lessons were learned from accidents and incidents.

Using medicines safely
● Most people's Medicine administration records (MAR) charts did not include photographs, which would help to reduce the risk of medicines being given to the wrong person.
● People's care plans did not include guidance for staff on how to support people with their 'as required' pain relief medicines. Professionals told us, "There seems a general reluctance to administer the residents with adequate pain relief, when it has been prescribed to be given [As required]".
● Most medicines were stored appropriately. However, the storage facilities of medicines that required

stricter controls, were insufficiently secure.

The provider had failed ensure risks related to medicines were appropriately manged. This contributed to the breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff understood how to support people with their medicines and people received their regularly prescribed medications appropriately.
● MAR Charts had been accurately completed and all medications reviewed, and tallied with records available.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe and that their support staff were helpful and supportive. Their comments included, "Staff are good as gold" and "The staff come when you need them".
● Relatives were also complimentary of the staff team and said, "[The staff] are friendly and obviously care" and "They do care for [My relative]".
● Staff had a good understanding of their roles and responsibilities in relation to ensuring the safety of the people they supported. Staff knew how to report safeguarding concerns externally if this became necessary.

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 meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The service supported and encouraged visits from families and friends. Relatives told us they were able to visit when they wished and that there had been appropriate visiting arrangements in place during the COVID-19 pandemic.

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

Staff support: induction, training, skills and experience

- Staff files did not evidence that staff training had been appropriately updated and refreshed. No details of any training completed in 2022 was recorded in any of the three staff files examined.
- Staff told us they had completed some training in 2022. One staff member provided certificates that evidenced they had completed, medication administration, food hygiene, fire safety, manual handling and infection control training on one day in May 2022. The quality of training and staff members ability to retain the information provided is questionable when such a range of topics are covered in so short a period.
- At feedback, we asked the provider with support from their training provider, to review what training staff had completed in the last 12 months. This information was not provided.
- Care staff had received irregular supervision from the provider. However, the senior carer and designated deputy manager had not received recent supervision and there were no formal structures in place to ensure supervision was routinely provided.

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

- Staff told us team meetings occurred infrequently, but they were kept up to date with changes in people's needs via the handover process.
- People received care and treatment from staff who knew them well and had some understanding of their care needs gathered from observing the practices of more established staff. Staff told us the provider was approachable and regularly completed shifts to support the staff team.

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

- Systems for assessing and identifying people's needs prior to admission were not entirely effective. We reviewed the care record of one person who had moved into the service in early 2022. Their care records did not include a detailed assessment of this person's specific needs. A handwritten care plan was available, but this was very brief and did not provide sufficient guidance for staff on how to support the person.

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.

● The provider and staff team had limited knowledge about this legislation, and people's capacity to make specific decisions had not been appropriately assessed.
● A number of people were living with dementia and their capacity to make decisions was variable. Staff told us they would prevent people leaving the service without support as this would be unsafe. The provider was unaware that DoLS applications were required when the freedom of individuals without capacity, were restricted.
● Following the inspection, we contacted the local authorities DoLS team who informed us two DoLS authorisations had been granted, subject to conditions, for individuals living in the service. At the time of our inspection the provider and staff team were unaware of these legal conditions being in place.
● Care plans included limited information about people's capacity to make decisions and the information available was often contradictory. For example, one person's most recent care plan identified that a person had full capacity. However, in relation to COVID-19 vaccinations, the service had sought consent for this treatment from the person's relatives rather than seeking consent from the individual.

The provider had not acted to ensure the rights of people who lacked capacity were protected. This was a breach of regulation 11 (Need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The service was relatively poorly maintained and in need or redecoration in communal areas. There were signs of water damage to areas of the lounge ceiling, and furniture in the lounge area was worn, and damaged. The condition of furniture made it more difficult to clean effectively.
● In communal toilets, mobility aids and handrails were rusty and floor tiling around toilets had been replaced with dissimilar tiles. These areas were unsightly and difficult to clean. In communal bathrooms, we also found that shower chairs were visibly stained, and walls discoloured.
● In one person's bedroom we found a small area, of approximately 12 to 18 inches long, where floor boarding was missing below the carpet. Although there was limited risk of people falling through this hole it did represent an unnecessary trip hazard to staff while supporting this person to be repositioned in their bed. The provider was aware of this issue but there were no plans in place to complete the necessary repairs.
● Flooring in the service's laundry room was worn, damaged in areas and difficult to clean.

The environment of the service and its equipment had not been appropriately maintained. This was a breach of regulation 15 (Premises and equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service was clean, and relatives told us, "It is clean, and it does not smell".

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

● People's preferences, likes, dislikes, and dietary requirements were understood by the staff team. People were complimentary of the food provided and one person said, "Breakfast was good, I had Weetabix with warm milk and no sugar, just how I like it".

● There were two hot meal options available at lunch time and staff supported people appropriately during mealtimes. Relatives told us, "The food smells gorgeous" and "I think the food is ok".

● People were offered drinks regularly and staff had ensured people were able to access drinks when they wished.

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

●The provider's systems for recording advice and guidance from professionals were ineffective. Information received from professionals was recorded on a daily hand over sheet and shared with staff when they came on shift. These records where then supposed to be reviewed by the provider and transcribed into the person's care plan by the provider. This work had fallen behind, and staff were unable to readily access records of guidance from professionals.

● Staff worked with involved health care professionals to ensure people's needs were met.

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 Good. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

Planning personalised care
Prior to this inspection we received information of concern that indicated people's care plans were inaccurate and out of date.
At this inspection, we found this information was correct. People's care plan's had not been regularly updated and did not reflect their current support needs.

- People's care plans were inaccurate and out of date. They did not accurately reflect current care needs or provide staff with the information they needed to care for people. For example, one person's care plan stated they were an amputee, but this information was inaccurate. Another person's care plan identified that they were able to walk with aid from a frame and regularly spent time in the lounge. We visited this person in their room and found from daily care records and observation that they were unable to mobilise independently, were cared for in bed and were currently unable to use the stair lifts necessary to access the lounge from their bedroom.
- Most people's care plans had been drafted in 2018 and were misleading. In addition to formal care plans a handwritten record of observed changes in people's needs had been maintained. It was difficult to access specific information about people's current needs from these records.
- The staff team knew people well and had a detailed understanding of their individual needs. A relative told us, "The staff are on the ball and are incredibly knowledgeable and helpful". However, staff recognised that people's care plans were inaccurate and one staff member commented, "I don't see [the care plans], I have nothing to do with them".
- Where people's health needs meant they needed specific support this was not accurately documented in people's care plans. For example, one person's records noted in some places that they had a specific health condition. This information was not consistently noted throughout the care plan and no guidance was provided for staff on how to manage associated needs. Staff confirmed the person had this health condition and were able to describe how to meet the person's specific additional support needs. As this information had not been documented there was a risk these needs would not be met.
- The lack of accurate care plans meant it was not possible for new or agency staff to quickly gain an understanding of people's support needs. This issue had been identified by the provider and staff team and when agency staff were expected on shift, a single sheet summary detailing everyone's needs was created to provide the agency staff member with basic information. Rotas showed and the provider recognised there had been occasions at night when the only staff awake in the service had been agency staff.

The lack of accurate care plans meant there was a risk to people's safety while being supported by new staff. This forms part of the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff handover meetings were held at each change of shift and information about any observed changes in people's needs were shared to ensure staff coming on duty had an understanding of people's current needs.
● Daily care records had been completed detailing the support each person had received.

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 also says that people should get the support they need in relation to communication.
● People's care plans did include some information about their communication needs. However, this information was out of date and inaccurate.
● One person's care plan included guidance for staff on the use of flash cards to support their communication and decision making. Staff were unaware of this support need and when asked were unable to locate these flash cards. Staff were able to communicate with this person but told us, "It's just what we pick up from [the person] as we got to know them".
● Where people used glasses or hearing aids or were experiencing difficulties hearing this information was not accurately recorded in their care plan.
● There was a notice board in the lounge designed to help people orientate to the date and current weather conditions. On the first day of the inspection, Tuesday 27 September, this board indicted the current month was August and that it was a Thursday. Inaccurate information does not assist people living with dementia to orientate themselves.

The provider had failed to accurately document people's communication needs and where specific needs had been identified appropriate support was not given. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● Staff supported people to engage with a variety of activities in the service's communal lounge and we observed numerous positive, caring and friendly interactions between people and their support staff. Relatives were complimentary of how staff encouraged and supported people to engage with activities and told us, "Often there are staff in the lounge in the afternoon singing and dancing."
● People told us they were supported to participate in a range of activities and their comments included, "We have plenty of entertainment, Monday music man, balloon lady for exercises and things on Wednesday, Thursday new lady with lots of equipment, music instruments. On Saturday the balloon lady comes again. There is lots going on" and "Last week we had a lady who came and massaged our hands, that was nice".
● Visiting by relatives and friends was actively encouraged and people were supported to maintain relationships that were important to them. During the COVID pandemic visiting had been facilitated in line with national guidance.

Improving care quality in response to complaints or concerns
● The service did not have systems in place to ensure all complaints received were documented and investigated. One relative told us, "I have not had any response at all to the concern I raised with the owner".
● We asked the provider for details of any complaints, concerns, or compliments recently received. The provider told us they had not received any. However, a number of thankyou cards and complimentary

letters from relatives with recent dates were displayed on notice boards in the lounge and hallway.

The providers failure to document complaints and concerns forms part of the breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- The service worked with professionals to ensure people were able to access necessary pain relief at the end of their lives.

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 changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership.

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

- The service was not required to have a registered manager and no managers were employed at the time of the inspection. The provider lived near the service and was responsible for leading the staff team and managing the service's performance.
- In the period since the last inspection the provider's personal circumstances had impacted on their ability to manage the service. The provider accepted this had been the case.
- The service had been led, in recent months, by two dedicated senior carers who were often working additional hours providing care to ensure people's safety. This meant there was limited resource and capacity available to focus on leadership and monitoring the service's performance.
- The provider had identified and one of the senior carers had agreed to become the service's deputy manager. However, this staff member had not yet been formally appointed to this role and recognised that current staffing shortages meant they would be unable to focus on management until additional staff were recruited. Professionals told us, "I feel that many of the issues that I have stated would be resolved with good leadership in the home."
- The service's records were highly disorganised. When asked for specific information including care plans and daily care records, staff and the provider experienced significant challenges in locating the requested information. Once found, as detailed in the response section of this report, these documents did not accurately reflect people's current needs.
- Information and paperwork were stored haphazardly. In the providers office, staff files and care records were not stored securely and instead kept in disorganised piles, in numerous locations throughout the room. As detailed in the effective section of the report we noted the provider did not have an effective system in place to record details of the training staff had completed and during the inspection we found some staff had completed additional training not recorded in their staff files. We asked the provider to review their records in relation to staff training with support from their training provider and to update the commission following the site visit. This information was not provided.
- Quality assurance systems were ineffective and had failed to identify the issues identified during the site visit.
- The provider had not made necessary notifications to the commission as required.

The provider's systems had not ensured compliance with the regulations. This a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics

● The culture of the service was caring and supportive. The provider and dedicated staff team were focused on ensuring people's needs were met. Staff regularly worked additional shifts at short notice to ensure people's needs were met. People were complimentary of the staff team and told us, "It is a nice place to live" and "Staff are good, they look after me well".

● Staff were dedicated and well-motivated. One staff member was a relative of a person living in the service and there was a relaxed 'family style' atmosphere in the service. People were confident asking for support and staff responded promptly to people's requests. Staff understood how to meet people's needs and told us, "I love it here" and "I wouldn't want to work anywhere else".

● Relatives all recognised and valued the compassion with which staff provided support. Their comments included, "[The staff] have been very good, very caring", "It is kind and the staff know the residents" and "[The Provider] adores the clients but I am a little bit concerned."

● However, the lack of effective leadership and challenging staffing situation meant the sustainability of current arrangements was becoming difficult. In recent months agency staff had been required to ensure safe staffing levels were achieved and systems did not enable agency staff to quickly gain an accurate understanding of people's needs.

● Staff ensured people were treated fairly and protected from discrimination.

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 provider and staff team had informed people's relatives promptly when significant events occurred. Relatives told us the service communicated openly and said, "If something happens, they let me know quickly."

● The provider and staff team were open and honest throughout the inspection process and recognised that improvements were required.

Working in partnership with others

● The staff team worked collaboratively with involved health care professionals to ensure people's needs were met.

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<br><br>The provider had failed to accurately document people's communication needs and where specific needs had been identified appropriate support was not given. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had not acted to ensure the rights of people who lacked capacity were protected. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The environment of the service and its equipment had not been appropriately maintained. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had not completed necessary pre-employment checks for all staff. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure enough |

suitably skilled staff were available to meet people's support 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<br><br>The provider had failed to identify or appropriately mitigate risks related to people's care needs, medication needs, the environment of the service and the use of new or agency staff. |

**The enforcement action we took:**

A warning notice was issued.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's systems had not ensured compliance with the regulations |

**The enforcement action we took:**

A warning notice was issued.