

AKM Care

East Cosham House

Inspection report

91 Havant Road
Cosham
Portsmouth
Hampshire
PO6 2JD

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15 January 2021
25 January 2021

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22 April 2021

Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

Requires Improvement



Is the service well-led?

Requires Improvement



Summary of findings

Overall summary

About the service

East Cosham House is a residential care home providing personal care to 23 people aged 65 and over at the time of the inspection. The care home can accommodate 24 people in one adapted building.

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

Care plans and risk assessments did not always contain the detail they required. In some instances, some people's individual risks had not been assessed placing them at risk of harm.

Infection, prevention and control practices were not always carried out safely. The provider had a policy in place however, this had not been updated. The COVID-19 policy did not follow government guidance.

There was no systematic approach to determine the number of staff required and to effectively deploy staff with the range of skills required in order to meet the needs of people using the service and to keep them safe.

Quality assurance systems had not been effective in identifying the concerns we found at this inspection and bringing about improvement.

The duty of candour had not always been followed and the registered manager did not have a full understanding of what duty of candour meant. The duty of candour is a statutory (legal) duty to be open and honest with 'service users' and their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. CQC was not always notified about significant events that occurred at East Cosham House. The local authority safeguarding team was not always told when a safeguarding incident occurred.

Medicines management was not always carried out safely, improvement was required with medicines records. We have made a recommendation about this.

Lessons were not always learnt when mistakes had happened. We made a recommendation about this.

Safe recruitment practices were followed; the required checks were carried out to protect people from the employment of unsuitable staff. IPC training was out of date for some staff.

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.

Staff were positive about the management of the service and told us the registered manager was supportive and approachable.

People were supported to access other healthcare services in a timely way.

The registered manager had considered the environment for people living with dementia.

The registered manager demonstrated a willingness to make improvements and during the inspection began reviewing some of their systems and process to initiate the changes we had identified as being required.

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 under the previous provider was Requires Improvement, published on 16 April 2020.

Why we inspected

We received concerns in relation to the safeguarding, staffing and non-notification to CQC of incidents. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. This is the first inspection of this service since they have had a new provider.

We are unable to give an overall rating for this service because the effective, caring and responsive domains were not inspected.

We have found evidence that the provider needs to make improvements. Please see the safe 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.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, infection control, assessing risk, safe staffing, duty of candour and good governance 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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

East Cosham House

Detailed findings

Background to this inspection

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

This inspection was conducted by two inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

East Cosham House 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection

We gave very short notice of the inspection because of the Covid-19 pandemic. Inspection activity started on 15 January 2021 and ended on 5 February 2021. We visited East Cosham House Home on 15 and 25 January 2021.

What we did before inspection

We reviewed information we had received about the service since the new provider became responsible for the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-

We spoke with four people who used the service and ten relatives about their experience of the care provided. We spoke with ten members of staff including the director, registered manager, deputy manager, care workers, kitchen staff and a housekeeper.

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

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records, policies and a further two people's care records.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This was the first inspection for this service which has been newly registered following a change in provider. This key question has been rated 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.

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from the risk of abuse despite the provider having a robust safeguarding policy and procedure in place which detailed the correct process to follow in the event of an allegation of abuse.
- Systems in place to safeguard people from abuse had not always been followed. For example, we received a whistleblowing safeguarding concern. When we spoke to the registered manager about this, they confirmed they had been aware of the safeguarding concern. However, they had not ensured this was fully investigated or informed the local authority safeguarding team or CQC. This meant people remained at risk of abuse as enough appropriate action had not been taken to ensure their safety.
- Not all staff had a robust understanding of safeguarding adults. One staff member told us, "We may have done [had safeguarding training] I can't really remember. I've never seen anything really [abuse] I like to get on and do my work I don't take no notice of what other [staff] are doing." A second staff member told us, "I have not received any safeguarding training from the service." Two staff members told us they didn't know of any external services where they could report safeguarding concerns.
- Two staff told us if they did have any concerns, they would report them to a senior or the registered manager and it would be dealt with appropriately. However, another staff member was not confident concerns would be dealt with. They gave us an example of concerns they had raised which had not been dealt with appropriately. They told us, "[Registered manager] is a lovely person don't get me wrong but I don't think his management skills are up to date, there are a few things I've asked him or told him about certain staff members and nothing has been done about it."

The failure to safeguard service users from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was responsive to our concerns and following the inspection told us they had implemented a new system to ensure all safeguarding concerns are reported to the appropriate authorities immediately.

Assessing risk, safety monitoring and management

- People's care plans and risk assessments did not always contain the information needed to keep people safe. Where people had specific health conditions there was not always an associated care plan or risk assessment. For example, one person had an allergy to two medicines, there was no risk assessment detailing how this allergy presented itself and what action to take should they get access to this medicine.

- Some people lived with diverticulitis (digestive condition that affects the bowel). There was no care plans or risk assessments associated with this condition. Staff told us they had some knowledge about this in relation to foods people can eat. The kitchen staff we spoke to told us they had folders in the kitchen detailing what foods people who lived with diverticulitis could have. There was no information detailing the symptoms or the signs to look out for. There was a risk that new or unfamiliar staff would not be aware of the risks associated with giving people food that could irritate could have significant negative impacts on the person and their condition. There was a risk that staff would be unable to recognise the symptoms which may require medical treatment.
- Risks to people were not always managed safely and improvements were needed to ensure people remained safe. For example, one person was on blood thinning medicine. There was a risk assessment in place however, it did not contain enough detail to minimise the risks. For example, it did not include the risk of bruising or excessive bleeding associated with blood thinning medicines. This meant staff may not be aware of the signs to look out for to keep people safe. We spoke to the deputy manager about this who updated the risk assessment immediately.
- Some people were prescribed paraffin-based creams to alleviate skin conditions. These creams are flammable, but risks associated with this had not been assessed and no mitigation plans had been put in place. This increased the risk of harm to people.
- The provider had not identified which people were in the clinically extremely vulnerable group and at risk of developing serious health complications if they contracted Covid-19, and no risk assessments were in place. No action had been identified or taken to reduce risks from Covid-19 for these people.
- Fire safety had been considered, regular drills took place, equipment had been tested and was in date and people had personal emergency evacuation plans in place. However, some of these required more detail for example, they did not always cover the difference between day and night evacuations and did not always detail the support each person need in order to evacuate safely. We spoke to the deputy manager about this who told us they would add more detail.

Systems were either not in place or robust enough to demonstrate risks were effectively managed. The failure to effectively assess, monitor and mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager and deputy manager were responsive and addressed some of the concerns immediately and told us what they would do about others.
- The provider was following best practice guidance regarding unwitnessed falls and monitoring of the person for a head injury.
- Risks relating to the environment were managed safely for example, window restrictors were in place, where required.

Staffing and recruitment

- There were insufficient ancillary staff employed. One cleaner was employed. They had started the day before the inspection and worked 20 hours a week over five days. The registered manager told us, "Officially we should have two cleaners. Now we have one cleaner and the handyman who is helping out." This meant a cleaner was not available every day and essential cleaning to reduce the risk of infection was not being completed regularly. A member of the kitchen staff was also on long term sick and a care staff member was helping in the kitchen. They had the appropriate food hygiene certificate.
- There was an activities coordinator who was employed to work between 10am and 3pm for activities four days a week. There was no activities coordinator on Wednesday, evenings or at the weekends. This meant that meaningful engagement only took place some of the week. A relative told us, "I don't think that they are

doing any activities during lockdown to keep residents occupied."

- Staff told us there were insufficient carers at night and in the mornings. One staff member told us, "Not [enough staff] in the mornings, an extra carer in the mornings would be good it's just not enough." A second staff member said, "I don't think there's enough staff on nights there's only two people [a senior and a care assistant]. The atmosphere sometimes in the morning is horrendous because they want us to get everyone up in the morning, but we do leave about five people in bed in the morning." They told us six people require two staff to support them and if another person requires support at that time, they said, 'Unfortunately there isn't much that we can do.' A third staff member told us, "I think we could do with an extra staff member in the morning. We prefer them [people] to all be together when they're eating so we can keep an eye on them instead of having to go from the kitchen to peoples room, so having another person in the morning to get people up would be great." We spoke to the registered manager about this who told us staff are not expected to get people up prior to the day staff coming on duty. They told us they would address this with staff.
- People and their relatives told us there were enough staff and one person told us, "Well, for me there is [enough staff]."
- We reviewed the rota and made observations during the inspection. We spoke to the registered manager about staffing levels, they told us they did not use a formal dependency tool but observed staffing levels and care needs to assess how many staff were required. Dependency tools assist providers to plan staffing levels based on the needs of people using the service. The lack of a formal dependency tool meant the service did not have a valid and consistent basis for estimating care needs of people. The registered manager told us they would look at guidance and start to use a formal dependency tool.

The failure to have a systematic approach to determine the number of staff required and to effectively deploy staff with the range of skills required in order to meet the needs of people using the service and to keep them safe at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were recruited safely; the required checks were carried out to protect people from the employment of unsuitable staff. For example, disclosure and barring service (DBS) checks and obtaining up to date information about staffs conduct in previous employment. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.
- New staff were introduced to people prior to providing any support and worked alongside more experienced staff to learn about people's needs.

Preventing and controlling infection

- People and staff were not always adequately protected from the risk and spread of infections, including COVID-19. On arrival our temperature was taken however, we were not asked to complete a form which identified our recent contact with people. We spoke to the deputy manager about this who told us they do have visitor forms, and this had been overlooked when the inspectors arrived. We were not asked to complete the form when we raised this. There was hand gel available at the entrance which we used.
- There was an infection control policy however, this had not been updated since the service became aware of the coronavirus pandemic. The provider had put a COVID-19 policy in place however, this did not follow government guidance. For example, it advised staff and people to isolate for seven days from the outset of symptoms of COVID-19 or a positive test. This policy did not identify which personal protective equipment (PPE) should be worn nor did it describe what processes should be followed if the home had an outbreak of COVID-19. We spoke to the registered manager about this who told us, "It was written at the start of COVID, we haven't updated it. We will review it and update it."
- There was not a clear identified area for staff to put on and take off PPE. Masks and aprons were kept in

the kitchen. Gloves were available in various areas around the home and face shields were kept in the cellar. Staff disposed of their PPE in clinical waste bins in toilets around the home. This meant staff had to enter the home and access the kitchen first prior to obtaining a face mask and apron. We spoke to the registered manager about this who told us, "Staff normally enter through the kitchen to put on masks and aprons." They told us following the discussion they would review and identify an area specifically for putting on and taking off PPE and would provide staff with facemasks to take home so they could arrive with a mask on.

- Cleaning schedules were in place however, the cleaning of touch points was not recorded. One staff member told us, "I don't know about the other [staff], I don't clean on the same days as them so I don't know what they're doing, but on my days I clean them all [high touch points] I only get four hours to do it all in, so I do what I can." This cleaning was not documented. A night staff member told us, "I clean them every night that I'm on... I don't know if they're cleaned any other time, I know they're cleaned when I'm there." They told us there is nothing on the cleaning schedule for, "light switches and things." This meant that some staff members cleaned touch points however, there is no evidence to confirm this. There was no process in place to ensure touch points were regularly cleaned.

- We asked a staff member if they had completed infection, prevention and control training. They told us, "I didn't, no, because I'm not a senior, but as far as I'm aware the seniors have." We reviewed the training matrix for infection, prevention and control training (IPC). Seven staff had not received IPC training since January 2020 which was prior to the Coronavirus outbreak. The failure to ensure all staff had received IPC training placed staff, visitors and people at risk of infection.

- A housekeeper told us, "I'm not very happy with the cleaning products situation. I'm using the same dirty old cloths for all the rooms, toilets and that as well." We spoke to the registered manager about this, they told us, "We have now got a different firm on board for cleaning products, they are now in place and we have a regular order." The registered manager told us they completed informal infection, prevention and control audits by observing staff use of PPE. This was not documented.

The failure to effectively assess and control the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The laundry room was clean and organised. There was an effective system to reduce the risk of cross contamination between dirty linen and clean linen. There were two separate sinks available one was a sluice and another for handwashing.

- We were assured that the provider was accessing testing for people using the service and staff.

- The kitchen was clean and well organised, opened food had been labelled with the date of opening. The service had achieved a food hygiene rating of five from the food standards agency. This rating means that the business was seen as very good by the food standards agency. Food hygiene ratings are grades given to food handling businesses after an inspection has assessed how well they comply with food safety law.

- We observed staff wearing PPE appropriately throughout the inspection and hand sanitiser was available in the home.

Using medicines safely

- Systems in place did not always ensure the safe and proper management of medicines. For example, although 'as required' medicines protocols were in place they did not have enough detail and were not person centred. One person was prescribed an inhaler for asthma, the protocol stated, "Dose - 1-2 puffs, maximum to be given 4 times a day," however, then went on to say, "maximum 4 puffs a day." This could be confusing for staff and may result in the person having all their doses for the day after two administrations of the inhaler or the person being administered too many doses if they had four doses of two puffs. It was not clear what the rationale was for administering one puff or two puffs. The 'as required' medicine protocol did not identify what signs to look for and advised staff to contact the GP if the medicine did not have the

desired effect. There was no detail to describe what the desired effect was. People were at risk of not being supported safely by staff who may not understand the risks.

We recommend the provider seeks current guidance and best practice and update their practice accordingly to ensure enough detail is included in 'as required' medicine protocols.

- Medicines and prescribed topical creams were in date and creams had the date of opening written on them. This would help ensure topical creams were not used when they were no longer safe. A medicines fridge was available in the kitchen. This was locked to ensure medicines were safely stored.
- Medicines were checked to ensure they were stored at the correct temperature and we observed these were all within the correct range.
- The new provider told us they would increase the number of audits to weekly. They told us they would conduct audits for all regular medicines and another separate audit for PRN medicines.
- Staff had been trained in the administration of medicines and had their competency checked six-monthly.

Learning lessons when things go wrong

- Systems and procedures did not always ensure lessons were always learnt and action taken when things had gone wrong. We found risk assessments and care plans were not always reviewed following incidents. For example, where a person choked on a piece of cucumber, care plans and risk assessments had not been updated. The care plan and risk assessment did not detail sufficiently how to manage any future similar incidents. This meant that people were at risk of staff being unaware of how to support them appropriately in a similar situation. A referral had not been made to the speech and language therapy team (SaLT). We spoke to the registered manager about this, they told us, "I will get a SaLT referral for this person, it was a one off." Following the inspection, the registered manager told us they had updated the care plan and risk assessment.
- The provider had a system to record accidents and incidents.

We recommend the provider seeks current guidance from a reputable source and implements processes to identify, investigate and review lessons learned when things have gone wrong and update their practice accordingly.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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 duty of candour is a statutory (legal) duty to be open and honest with service users and their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. When incidents had occurred, although the registered manager had informed people and their families, they had not followed this up in writing with an apology.
- The registered manager did not understand their responsibilities under the duty of candour. We spoke to the registered manager about this, he told us, "I must look into it more as I don't understand it." We have sent the registered manager links to guidance.

The failure to follow their duty of candour and provide written notification to relevant people was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was a quality assurance process in place consisting of a range of audits, including: medicines management, infection control, environment and care plans. However, the systems had not been effective in identifying the concerns we found at this inspection such as risk management, reporting safeguarding concerns and ensuring that medicine records were detailed. This meant people were at risk of not receiving safe care which met their needs and wishes.
- Additionally, the provider had not ensured government guidance in relation to infection control was being followed. More information about this can be found in the safe section of this report.
- There were processes in place to help ensure, if people came to harm, relevant people would be informed in line with the duty of candour requirements. However, CQC were not always notified of all significant events. A whistle-blower notified us of a safeguarding concern which the registered manager had not notified CQC about. You can read more about this in the safe section of this report. We spoke to the registered manager about this who immediately arranged for this to be sent to CQC. The registered manager told us they have updated their monitoring system to ensure all future notifications were sent to CQC when required. The provider had not contacted all the other relevant people including the local authority safeguarding team and family members.

The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and contemporaneous records was a breach of Regulation 17 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was responsive to our feedback and either acted promptly to make improvements or told us of their plans about some of the changes they were going to implement following the inspection.
- Staff were supported to understand their roles and responsibilities through supervisions. Team meetings had not been held regularly since the COVID-19 pandemic was identified.

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

- Improvements were needed to ensure people consistently received safe, empowering, high-quality care and good outcomes. These have been reported in the safe domain of the report.
- Some people told us they were happy with the service. For example, one person told us, "I love it, especially the woman, [deputy manager] I'm not joking." Others told us, "It's alright. Everybody knows everybody. I don't know if I've got my family or not. There is some sort of virus going about so I can't see anybody," and "Sometimes, they [staff] are up, and sometimes down, a bit like my mood."
- Relatives comments were mixed, they included, "[Staff] always let know if anything is wrong or tablets [medicines] are changed, we were involved with the care plan when [person] was admitted to home, staff seem very good, whenever you ask them anything they're very nice", "I don't think that they are doing any activities during lockdown to keep residents occupied" and, "It's not the nicest of places, rather old fashioned, but it is clean, could be brighter and nicer, but what's important is the care of [person], and they look after them very well."
- Staff said they enjoyed working at East Cosham House. For example, one staff member told us, "I'm quite happy in my job and the staff, I don't have a problem with other staff."
- Staff told us they felt supported by the registered manager who was approachable and visible throughout the service. Staff were in the process of getting to know the new provider, one staff member told us, "To be honest at the moment it's a little bit iffy, we've just had a new owner take over so trying to get things in that we need is a bit of a pain but that's not our manager that's the owner – cleaning products, we normally have white aprons with blue gloves for personal care, blue aprons and white gloves for food but at the moment we have no blue aprons which is frustrating."
- The registered manager told us things had been difficult since the last inspection due to changes in the provider and with COVID-19. They felt this had contributed to some of the issues identified during the inspection.
- People were supported to stay in contact with their family during the pandemic via video and phone calls. Most relatives told us staff contacted them to keep them up to date with what had been happening and any changes made at the home.
- The registered manager was not allowing window visits during lockdown. We spoke to the registered manager about this, they told us, "We have misunderstood the guidance, if someone insisted, we wouldn't stop window visits. We will make sure window visits can take place for people and relatives from now on."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People's protected characteristics had not always been considered, one person talked to us about their needs around their sexuality and told us these had not been addressed. We looked in this person's care plan and there was no mention about this person's needs specific to their sexuality despite this information being highlighted in the local authority assessment. This meant this person's needs were not being met which may have added to their depression and anxiety. We spoke to the registered manager about this who told us, "I meet with [person] at least once a week to discuss how they are feeling and to openly discuss their sexuality."

We have discussed accessing groups when COVID-19 restrictions are lifted." The registered manager told us they would input a care plan and ensure all the relevant detail was included to ensure staff knew how to support this person appropriately.

- The registered manager told us about their links to the community. This involved various churches and entertainers coming to the home pre COVID-19. However there had been a lack of access to outside entertainment since lockdown was reintroduced. There was one activity coordinator employed for 20 hours a week, the registered manager told us they intended to recruit another activity coordinator, but it was difficult during lockdown.
- Staff were supported with regular supervision however; team meetings had not taken place during the coronavirus pandemic. Information was shared with staff at handover and on staff notice boards.
- Some relatives we spoke to felt there were not enough activities to keep people entertained. On the day of the inspection we observed the activities coordinator dancing and singing with people who were sat round the edge of the room. Some people looked interested while other people were not engaging. The registered manager came in and played some older music. More people became engaged and were singing along to the songs. The activities coordinator was keeping a record of the activities people enjoyed.
- People's families told us they were kept informed about their relative's health and were involved in care planning and decision making, where appropriate. One relative told us, "I was involved in best interest meeting, mental capacity assessment, risk assessment and Deprivation of Liberty (DoLS)." Another relative commented, "We were involved when [person] seemed to be losing weight, and they put her on supplements, she also has a DoLS order."
- Most staff we spoke to told us they felt supported in their role and the registered manager was available to offer support.
- The service worked in partnership with other professionals to ensure people received effective, joined up care. Documents demonstrated people had access to a range of professionals when required or requested.
- Links had been established with local groups, for example, local primary schools who prior to COVID-19 would come into the home at Christmas to sing carols.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Systems were either not in place or robust enough to demonstrate risks were effectively managed. The failure to effectively assess, monitor and mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>Systems to assess and control the risk of infection were not in place. The failure to effectively assess and control the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The failure to safeguard service users from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act</p>

2008 (Regulated Activities) Regulations 2014.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 20 HSCA RA Regulations 2014 Duty of candour

The failure to follow their duty of candour and provide written notification to relevant people was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The failure to have a systematic approach to determine the number of staff required and the range of skills required in order to meet the needs of people using the service and to keep them safe at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 20014.