Amicura Limited

Temple Court Care Home

Inspection report

Albert Street
Kettering
Northamptonshire
NN16 0EB

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13 May 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Temple Court Care Home is a nursing home for older people and people living with dementia. The service is registered to provide personal care to up to 54 people.

On the first day of our inspection, there were 21 people at the service, by the end of the second day of inspection all people had been supported to move to alternative care providers by care commissioners.

People's experience of using this service and what we found
The provider failed to have sufficient managerial and clinical oversight to ensure people were cared for safely.

Since early April 2020, the registered manager and the senior care team had been absent from the service, the clinical lead was also on prolonged leave. In the absence of the registered manager, senior care team and clinical lead, the provider failed to ensure they had sufficient oversight of the service.

People's risks had not always been assessed or updated regularly as people's needs changed. People's care plans did not always reflect people's current needs. Staff did not have enough information about people's current needs to provide safe care that met their needs.

The provider failed to deploy enough staff with the skills, competencies and supervision to carry out their roles safely. Staff had not received all the training they required, or had their competencies checked, to ensure they could meet people's needs. New, agency and deployed staff did not receive an adequate induction or receive supervision which led to poor care.

People were not protected from the risks of abuse or poor care. Staff did not identify or report where people had come to harm, or report incidents, accidents and unexplained bruising. Following visits by commissioners a number of safeguarding referrals were made for people.

People's health deteriorated and was at risk due to the lack of clinical and managerial oversight of their medicines, falls, mobility, wound care, pressure area care, clinical observations and infection prevention and control. Staff failed to take prompt action to seek medical care where people displayed signs of ill-health or failed to receive their medicines.

People were identified as being malnourished and dehydrated. People were at risk of malnutrition and dehydration as staff did not provide food and drink that met each person's needs. The provider failed to ensure there was sufficient oversight and monitoring of what people ate and drank or monitor their weights. Staff failed to identify and refer people to health professionals where people lost weight.

The provider failed to ensure that people were involved in the planning of their care. People's dignity and

respect was not always maintained as people did not receive all their care and provision was not made for their mental and physical well-being.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice.

The provider failed to have adequate systems to identify failures in staffing and the quality and provision of safe care. Audits had not been completed and the provider failed to learn from incidents or complaints. They failed to have sufficient managerial or clinical oversight to identify where things went wrong or have processes to analyse the cause.

We have identified breaches in relation to the management of risks to people, meeting people's eating and drinking needs, staffing deployment, staff training, people's dignity and the governance of the service at this inspection.

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 requires improvement (published 25 June 2019), the provider was in breach of regulations 12 and 17 and we placed conditions on their registration. Since this rating was awarded the registered the provider has altered its legal entity. We have used the previous rating and enforcement action taken to inform our planning and decisions about the rating at this inspection.

Why we inspected
We received concerns in relation to people's nursing care needs, health needs, medicines, wound care and nutrition and hydration needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. Following the inspection and identified safeguarding concerns a criminal investigation is in progress.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Temple Court Care Home 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 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.

Following this inspection we took urgent action to impose a condition to restrict admissions and readmissions to the service. We did not take further civil action as there was no one living at the service and the provider cancelled their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Temple Court Care Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by three Inspectors.

Service and service type
Temple Court Care Home 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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the service registered and sought feedback from the clinical commissioning group and local authority who commission care from the provider. We also received feedback from community nursing staff who had been deployed to provide oversight of the clinical care provided to people in the home.

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
During the inspection we spoke with four people who lived in the home and two people's relatives. We spoke with seven members of staff, including care staff, senior care staff, nursing staff, the registered manager, operations manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with six of the community nursing staff who had been deployed to the home to oversee people's care and monitor their safety.

We looked at multiple records about people's care needs and medicine needs. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, rotas and training information for staff.

After the inspection
We spoke on the telephone with six people's relatives and two care staff.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate: This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider failed to keep people safe from unsafe care and treatment. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014. The service had deteriorated at this inspection and the provider continued to be in breach of regulation 12.

Assessing risk, safety monitoring and management

● At the last inspection we found risks to people had not always been identified and managed safely. At this inspection people were at risk of harm as the systems to manage people's risks was ineffective. People's care plans and risk assessments were not always available for staff to refer to and the information in their care plans did not always reflect their current needs. Staff did not have up to date information about people's risk of falls, how to manage moving and handling, use of bed rails, pressure relieving equipment and people's current health status.

● People did not receive the support they required to mitigate their risk of falls. One person's relative told us, "[Family member] was supposed to have an alarm mat so if they got up staff would know. Often it wasn't plugged in, or staff didn't put it near [family member]." We saw several people had experienced numerous falls, some of which had caused them injuries requiring hospital treatment. No action had been taken to prevent further falls, and people continued to fall and incur injuries.

● People who were at risk of acquiring pressure sores did not receive the care and support to relieve their pressure areas to prevent pressure area injuries. Records showed staff had not repositioned people often enough to relieve their pressure areas, or repeatedly repositioned people onto the same areas, resulting in pressure area injuries. For example, people's feet were pressed against the board at the end of their beds; people acquired pressure sores to their feet as a result.

● The provider failed to ensure clinical oversight of people's wounds. Agency nursing staff did not have access to information about people's wounds, how often they required dressing, or the treatment plan for each wound. Where dressings had been applied, the wrong type of dressings had been used, causing further trauma to their wounds. Some wounds had been dressed using inappropriate methods, which had caused additional injuries to limbs. Wounds had deteriorated, areas had become necrotic and some had become infected, requiring people to need hospital treatment.

● Environmental safety measures were not effective. Water was not maintained at safe temperatures putting people at risk of scalds from very hot water. People had access to areas that could pose a risk to their health and safety, such as kitchens, sluices, unoccupied rooms and areas undergoing maintenance.

Preventing and controlling infection

● The provider failed to have adequate systems to manage waste and infection control procedures were not

consistently followed.
● At the time of inspection, water repellent face masks, gloves and aprons were readily available, however, (PPE) was not disposed of in a safe way, putting people at the risk of infection.
● We observed staff were not always sure of how to dispose of soiled and contaminated linen.
● The provider failed to have a system to monitor and seek prompt medical care for infected wounds. Two people had infections in their wounds; the provider had failed to ensure strict adherence to safe wound dressing guidelines to prevent infection.
● The provider failed to ensure areas of the home were clean or maintained in a way to mitigate infection risks. One person's relative told us they visited following a fall their family member had experienced and found dried blood still on the wash basin two days later.
● The provider failed to ensure areas that were used to prepare food and drink were hygienic. On the first day of inspection we saw the servery on the second floor was dirty, bins were full to the top with food waste and had no lids. Tea, coffee and sugar was in dirty containers with no lids. The shelving in the fridge was stained and ingrained with old food and drink.

Using medicines safely
● People's medicines were not safely managed, and people did not receive their medicines as prescribed.
● The provider failed to ensure there was clinical oversight of the stock of medicines. People did not always receive their prescribed medicines as staff failed to order stock in a timely way. People missed doses of their essential medicines. The failure of clinical oversight meant people were at risk of deteriorating health due to not receiving their medicines. For example, people did not receive their medicines for the prevention of blood clots, heart conditions, stroke, acid reflux, seizures and thyroid problems. Staff had not sought medical advice for the missed medicines.
● Staff did not always accurately record what medicines they had administered. People's records showed they had been given medicines, but the number of tablets in stock did not tally; indicating missed doses, or too much medicine being given.
● People's prescribed medicines to be taken 'as required' did not always have protocols for staff to follow. This is required to ensure people receive their 'as required' medicines as prescribed and the effect is monitored. People had been given medicines to calm their anxieties and behaviours; staff had not recorded why this had been given, or whether the sedation had had an effect.
● The provider failed to ensure there were sufficient dressings in stock to treat people's wounds. Agency staff recorded they had not been able to use the correct dressings as these were not available. There was no clinical oversight to ensure the correct dressings were ordered, even after this had been identified.

The provider failed to provide care and treatment in a safe way as they did not have adequate systems to assess the risks to the health and safety of people using the service or mitigate the risks. The provider failed to ensure there were sufficient quantities of medicines and dressings or ensure the safe management of medicines. The provider failed to adequately assess the risk and prevention of the detecting, control and spread of infection. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider failed to ensure there were enough staff deployed with the required skills and knowledge to provide care to meet people's needs.
● There were not enough staff deployed to meet people's needs. One person's relative said, "Carers are never around to take [person's name] back to bed, their [part of body] gets sore but there's no one available." Another person's relative said, "They [staff] were over run, they were short staffed and then with the influx of people they couldn't cope."

● Staff told us they could not cope with the workload expected of them, which resulted in people staying in bed, not receiving regular food, drink, personal care and repositioning. One member of staff told us many people needed two staff for personal care and help to eat and drink. They said, "Since Christmas all people [had] very high needs. [The] provider did not increase staffing." A member of night staff told us people missed out on evening food and drinks as they needed to ensure people received the personal care the day staff had not had time to do.
● Rotas showed there were very few permanent nurses deployed in the home, high numbers of agency nurses were used. The rota for the week beginning the 20 April 2020 showed all nurses deployed in the home were agency nurses. A member of night staff said, "The agency nurses only did the medicines. They would then go to sleep and only get up to do the meds that were due in the night. There were no permanent night nurses."
● The provider failed to ensure agency care and nursing staff received enough information about people's needs. For example, one person's needs meant they could only receive personal care from female staff. During the inspection we found two male agency staff who were unaware of this had provided their personal care.

The provider failed to ensure there were enough skilled and trained staff deployed to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risks of abuse or unsafe care as the provider did not have sufficient systems in place to identify or report all incidents.
● The provider failed to have a system record and report incidents, accidents and poor care. For example, unexplained injuries had not been reported to the appropriate authorities.
● People were subject to degrading treatment. One person's relative said, "Sometimes we would visit around 1.30 – 2pm. [Family member] was still in bed had been doubly incontinent and was covered in dried faeces." Community nurses deployed to implement clinical oversight and monitor people's safety in the home found people were left in soiled bedding for long periods.
● Following the deployment of community nurses in the home, a large number of safeguarding referrals were made for people, these are currently under investigation. The provider had failed to recognise these as safeguarding issues and failed to take action to protect people from risk of further harm.

The provider failed to have adequate systems in place to protect people from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider failed to have sufficient managerial or clinical oversight to identify where things went wrong or have processes to analyse the cause.
● The provider failed to prevent recurrence of accidents, incidents and injuries which placed people at risk of harm. Any systems that had been in place were ineffective.
● The provider did not have sufficient systems to identify where people could be at risk of environmental issues, or processes to take actions to mitigate the risks.

Inadequate

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- The provider failed to ensure there was clinical oversight of people's health needs. People's care records showed they experienced on-going ill health such as diarrhoea or deteriorating wounds; staff did not take prompt action to seek medical advice. Nursing staff had failed to consistently take people's baseline observations and use these to compare observations when people were unwell. There was no system to take people's clinical observations regularly or when they showed signs of ill-health. Staff failed to identify when people's health deteriorated and required prompt medical attention.
- The provider failed to have clinical oversight and ongoing monitoring of people's catheter care or planned changes of catheters. People were at risk of infection and harm as a result.
- The provider failed to have managerial oversight of staff. People failed to receive their medical care as staff did not follow the instructions of health professionals. We found several occasions where staff were advised to carry out observations of people's health or make follow up appointments and this was not done.

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

- The provider failed to ensure all people had been assessed for their needs. Where people had been moved from the hospital to the home during the coronavirus outbreak, they had failed to carry out a full risk assessment or plan of care to mitigate the risks. Where records were in place, the information was incomplete and inconsistent. This meant staff did not have all the information they required to meet people's needs which placed people at the risk of harm.
- People had been admitted to the home from hospital who required rehabilitation. There had been no consideration for rehabilitation and at least one person lost their mobility completely during their stay at the service. This was identified by the deployed community nursing team who arranged for people to be moved to a suitable provider who was able to meet their needs.
- People's assessments were not regularly updated as their needs changed. The provider failed to regularly assess and monitor people's health and well-being in line with legislation and evidence-based guidance.

The provider failed to ensure people's needs had been assessed, their risks mitigated and receive safe care that met their healthcare needs. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider failed to have adequate systems in place to ensure people received food and drink that met their nutritional needs. risks of malnutrition or dehydration for people had not been monitored, and there was no managerial or clinical oversight to monitor people's intake to ensure people's health and well-being.

● People did not receive the support they needed with eating and drinking. People were diagnosed by health professionals as being malnourished and dehydrated. Following the deployment of community nursing staff into the home, several people were identified as requiring medical treatment and were admitted to hospital with dehydration.
● People's relatives told us people were often hungry and thirsty when they visited them. One person's relative told us their family member never had a drink within in reach when they visited and was always very thirsty. They would immediately get them a drink, which they gulped down saying how thirsty they were. They also told us of an occasion when staff forgot to give their family member any lunch until relatives questioned this an hour and a half after lunch service.
● Staff told us they did not have time to meet people's nutrition and hydration needs. One member of staff said, "We didn't have time to get people out of bed or make sure they had enough to eat and drink. We needed to go into [Person's name] often as [they] would only take sips but we couldn't get to [them] very often."
● The provider failed to ensure staff had enough information to know whether people were at risk of weight loss, or required a specific diet, fortified foods or drinks. Staff completed records that showed people had been offered food and drink, but these were not always accurate. There was no oversight of these records to identify where people were not eating and drinking enough to maintain their weight. Where people had lost weight, no action had been taken to fortify their food and drink or refer them to health professionals for review.

The provider failed to ensure people's nutrition and hydration needs were met. This placed people at risk of harm. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider failed to ensure staff had received the training and support required to enable them to effectively carry out their role.
● Staff did not receive the training or have their competencies checked for key areas of their roles. Records showed a high proportion of staff had not received training in health and safety, manual handling, fire safety, infection control, equality and diversity and food safety. People came to harm as a result of the lack of training, including pressure sores, infections and poor nutrition and hydration.
● New staff, agency staff and staff deployed from other homes did not receive an induction, which meant staff did not know how to raise concerns or report changes in people's well being.
● The provider failed to implement an effective plan of supervision and appraisal. The care provided to people reflected the lack of supervision and support available to staff. People had not been provided with care that met their needs in a safe and compassionate way and had experienced harm as a result.

The provider failed to ensure staff received the appropriate training and supervision required to carry out their roles safely. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● We found there had been a lack of oversight of people's mental capacity. Many people's care plans did not contain details of mental capacity assessments or best interest decisions. We discussed this with the registered manager who told us these were under review as they were not of sufficient quality.
● Where people did have capacity assessments these lacked detail regarding the assessment process and any associated best interest decisions.
● People's relatives told us their family member was unable to advocate for themselves, yet they were not asked for any information to support their care planning. Comments included, "We did not see a care plan or risk assessment or discuss what [family member's] care needs were." And, "Everything was rushed we never felt there was any care plan put together."

Adapting service, design, decoration to meet people's needs
● The environment was adapted to people's needs. However, would benefit from increased signage to support people to find their way around. For example, many people's bedroom doors were blank with nothing to support them to identify the room as their own.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider's quality assurance systems and processes were ineffective. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014. The service had deteriorated at this inspection and the provider was still in breach of regulation 17.

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

- The registered manager, and senior care staff had been absent from the service since early April 2020, the clinical lead had been absent for a prolonged period. The provider failed to ensure there was sufficient managerial and clinical oversight during this time period. The provider's internal quality assurance processes had not been used to monitor the service, the provider failed to identify the concerns with the adequacy, safety and quality of care. The provider failed to take the necessary action to provide safe care and secure compliance in relation to the regulatory requirements. This meant people living in the home were harmed and exposed to unnecessary and unacceptable levels of risk.
- The provider failed to ensure the service had the capacity, systems and processes to safely manage the admission of 15 people from hospital during the coronavirus pandemic. The provider and registered manager accepted the admissions in a short space of time and failed to ensure they had the resources to meet their needs. When the service was left with no management team, the provider failed to ensure there were sufficient suitably skilled staff deployed to provide managerial and clinical oversight. Staff did not have enough information or the capacity to provide safe care to meet people's needs.
- The provider failed to implement effective governance systems or processes and had not adequately assessed, monitored or driven improvement in the quality and safety of the care being provided. One person's relative said, "There was no control or leadership in the home, there was a lack of processes and procedures, it was chaos."
- People could not be assured of safe care and treatment as this was not being effectively monitored. There was a lack of managerial and clinical oversight of people's mobility, falls, skin integrity, wound care, health needs, medicines and nutritional and dehydration risks. People who were identified as at risk did not receive the care they required as staff were not following the systems in place to reduce this risk.
- Staffing deployment wasn't assessed or monitored to ensure people's safety. The provider had not effectively assessed people's needs and staffing requirements; we found staff deployment to be inadequate during our inspection. Staff were unable to deliver safe care and support due to the staffing skills mix and numbers, however, the provider had not identified this as an issue. Commissioners deployed their own care and nursing staff to ensure people's safety until they could be supported to move from the home.

● The provider failed to adequately monitor and improve the environment and infection control procedures during the coronavirus pandemic. This resulted in an unsafe environment where infection control risks were not adequately managed.

The provider failed to have suitable systems in place to assess, monitor or mitigate risks relating to people's health and welfare. This was a continued breach of Regulation 17 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance

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 provider did not promote a person-centred culture within the home. Staff did not care for people in a way that upheld their individuality and right to dignity and respect. One person's relative said, "[Person's name] never had their own clothes on, we visited one day, and they had someone else's dirty t-shirt on."

● The provider failed to ensure people were provided with adequate personal care to maintain their dignity and their skin integrity. People were seen to be unkempt and partially dressed. During the inspection we saw people were not dressed as they chose, people asked us to find items of clothing such as trousers for them to wear as they felt uncomfortable.

● Staff described people's behaviour changed as staff did not have time to get them out of bed or have time to support them to eat and drink. Staff and community staff that had been deployed by the commissioners described people's loss of hope; people showed signs of distress and depression

● Staff were not always considerate of people's circumstances and were not always sympathetic to people trying to maintain communication with their families. At times staff were insensitive to people's bereavement or the effect of not receiving the support they needed from their families. The provider failed to ensure people had enhanced communication set up, such as video calls to speak with their relatives.

● All the relatives we spoke with told us the provider failed to keep them informed or communicate with them about their family member. Comments included; "Communication was poor from the beginning, it was us [family] chasing them [provider and registered manager] all the time." And, "The first we knew about the lock down was when we came to visit."

● The provider failed to keep relatives informed of the conditions within the home, including people's deteriorating health.

The provider failed to ensure people were treated with dignity and respect. This placed people at risk of harm. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had not ensured statutory notifications were submitted to the Care Quality Commission (CQC) without delay. This meant they had not informed the CQC when serious incidents had occurred or when people died or incurred serious injury.

Failure to notify the Commission constitutes a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 (part 4): Notification of death of service user and a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4): Notification of other incidents. We are currently looking into this matter.

● In response to the concerns raised by commissioners and the action taken to support people to move

from the home, the provider wrote to people's families to inform them. However, during the inspection we saw that as people were being supported to move the nominated individual, registered manager and senior management staff were not visible or easily available to provide support to people or staff.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not provided with safe care and treatment.

The enforcement action we took:

We imposed a condition to restrict admissions and re-admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There was a continued lack of understanding, oversight and governance systems to ensure people received a safe service. Systems that were in place were not implemented effectively and had not identified the concerns with the service.

The enforcement action we took:

We imposed a condition to restrict admissions and readmissions to the home.