Leicestershire County Care Limited

Curtis Weston House

Inspection report

Aylestone Lane
Wigston
Leicestershire
LE18 1AB

Tel: 01162887799

Date of inspection visit:
02 March 2020
04 March 2020
11 March 2020

Date of publication:
24 July 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Curtis Weston House is a residential care home providing personal care to 40 younger and older adults. People using the service had a physical disability, sensory impairment, dementia, mental health needs and a learning disability or autistic spectrum disorder.

The care home accommodates up to 44 people across two floors, each of which has separate adapted facilities.

People's experience of using this service and what we found
People and visiting children were not protected from the risk of harm of abuse as the systems and processes in place to safeguard people were not effective. Incidents of abuse were not always identified, reported to safeguarding, the police or notified to the Care Quality Commission. Opportunities to learn from accidents and incidents were missed as not all incidents were reported.

The registered manager was not always present in the service. There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Quality assurance systems and processes failed to identify concerns relating to safe care. Where issues had been identified the service did not act in a timely manner to address these.

Care plans did not always reflect people's dietary requirements and people's risk of malnutrition had not been properly assessed. Not all staff working with people had the necessary training to support them safely. Staff had not had training to safely manage challenging situations.

Care plans and risk assessments did not contain adequate information for staff to know how to support people. Staff did not have time to read people's care plans, or time to spend with people which meant care was task focussed. People told us there was not enough to do. People's privacy and dignity was not always protected. People's preferences and wishes for the support they wished to receive at the end of their lives was not always detailed in their care records.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. Policies and systems in the service did not always support this practice. People's mental capacity assessments and best interest decisions had not always been undertaken and DoLS conditions were not always met.

We received positive feedback about the meals available and found health advice had been sought when concerns arose about people's health deteriorating. Staff were kind and caring in their approach and knew people well. They enjoyed spending time with people but had limited opportunities outside of meeting people's basic care 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 this service was Good (Published 16 October 2018). The rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding service users from abuse and improper treatment. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive 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 have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, need for consent, person-centred care, good governance and a failure to send legally required notifications to the CQC.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Curtis Weston House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors 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
Curtis Weston 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. The registered manager was also working in another role. This meant they were not always present at the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and seven relatives about their experience of the care provided. We spoke with 12 members of staff including the registered manager, manager, team leaders, care workers, chef, housekeepers and activities co-ordinator.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at three 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. This included, but was not limited to training data, quality assurance records, DoLS authorisations, policies and procedures.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems and processes were not effective in protecting people from the risk of abuse and improper treatment. The services statement of purpose said, 'We have zero tolerance of all forms of abuse.' However, we found incidents of abuse recorded in people's care records, that had not been identified by the registered manager, reported to safeguarding, the police or CQC.
- Records showed one person had assaulted people on six separate occasions. The person's risk assessment specified 15 minutes observations were required. However, records showed, and staff told us, these were undertaken every 30 minutes. Observations had not been effective in preventing abuse from occurring. This meant people, visitors and staff continued to be exposed to the risk of harm.
- People's risk assessments and care plans were not reviewed following incidents of abuse to identify lessons learned and to implement measures to reduce risk to people. The registered manager was not aware of these incidents. Opportunities to learn from incidents were missed.
- Adequate measures were not in place to protect visiting children from being exposed to a risk of harm. Staff had not received safeguarding children's training.
- Staff had a good knowledge of safeguarding procedures and how to refer concerns. However, records showed people had experienced harm from other people at the service. Staff had failed to act on these situations, despite having the knowledge on the processes to be followed.

The provider failed to ensure that people were protected from abuse and improper treatment. This is a breach of Regulation 13(1) Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Assessing risk, safety monitoring and management; Using medicines safely,

- Risk assessments and care plans did not contain enough guidance for staff to know how to respond to people's behaviour to keep themselves and people safe. One person's care plan instructed staff to distract them, it did not say how. We found staff's responses to people's behaviour were therefore inconsistent. One staff member said, "We are not consistent in approach, staff do what works for them."
- There were nine recorded incidents of aggression towards staff from one person since December 2019, including being 'thumped' and 'strangled'. Staff had not had training to safely manage violent situations, so did not have the skills to safely break away from a potentially violent person without harming them. Care plans and risk assessments did not contain enough guidance for staff to keep themselves safe.
- Risk assessments were not reviewed following accidents and incidents. One person had fallen whilst they were alone and outside the service. Their risk assessment was not updated following the fall to consider what was needed to support them to stay safe whilst in the community. Staff did not know what action they would take to keep the person safe if they chose to go out alone again. Another person had recently fallen,

their falls risk assessment had not been updated for nine months and did not reflect a bed sensor was in place.
● Risk assessments for identifying a person's risk of malnutrition had been completed incorrectly. Two people's risk assessments stated they were at low risk of malnutrition. However, we found they were both at high risk of malnutrition. They were not weighed as frequently as best practice guidance recommended. This placed people at risk of weight loss not being identified at the earliest opportunity and healthcare advice not being sought promptly.
● Medicine administration systems and processes did not identify incorrect times on a person's medicines record. This meant they were at risk of not receiving their medicines at the right time to manage their condition. There was no system in place to record the actual time of administration of this medicine. Staff were observed to handle medicines during a stock check without wearing gloves. There was a risk this could alter the medicines effectiveness.
● Risks to people from the environment had not always been identified. For example, exposed metal on a handrail, putting people at risk of skin damage and trailing wiring from wall lights causing a trip hazard to people using mobility equipment. A cupboard storing substances assessed as being hazardous to people's health, was observed to be unlocked on the first day of inspection. This meant people were not adequately protected from the risk of accessing hazardous substances.

The provider had not ensured all the relevant information was in place and that potential risks to people had been identified. Therefore, people were at risk of harm. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

● Staff did not administer medicines to people until they had been assessed as competent to do so, this included administering injections for the management of diabetes.
● Staff we spoke with had a good knowledge of people's medicines and how they liked to take them.

Staffing and recruitment
● Planned staffing levels were achieved and people were supported by a consistent staff team that knew them well.
● The registered manager told us, and rotas showed us night time staffing had recently been increased. One person reported staff had not always been able to respond quickly to their needs. We will assess the impact of increased night time staffing at our next inspection.
● People told us there were enough staff to meet their basic care needs. However, people reported staff did not have time to spend with them. One staff member said, "We don't always have the time to sit with people and talk to them, some people are really bored."
● Safe recruitment checks had been undertaken to ensure staff were suitable to work with people receiving care.

Preventing and controlling infection
● We found areas in the home that were an infection control risk such as damaged and stained flooring in the kitchen store, laundry, bathrooms, and toilets. These had been identified by the service but had not been promptly addressed. One person's bedroom carpet needed replacing as it smelt of urine, the timescale for replacement was 12 months.
● Care staff were responsible for maintaining the cleanliness of the home. There was a cleaning schedule in place. Whilst the home was clean and tidy in most areas, we found dusty areas such as lights and paintwork in communal areas and corridors. The entrance to the service and the smoking shelter were littered with cigarette butts. A relative told us, "The smoking room in the garden is covered in cigarette butts, no one is

tidying it, it's always a mess."

● Staff had access to personal protective equipment (PPE) such as gloves and aprons and we saw this in use.

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

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.

- Staff were unaware of people's DoLS conditions and we found they were not always met. One person's DoLS condition required staff to personalise leisure and social activities, and record in daily records what had been offered and how they responded. Records showed activities had been offered on only seven occasions since June 2019.
- Where people were no longer able to make decisions about certain aspects of their lives, this had not always been assessed and best interest decisions had not always been undertaken. For example, one person had a bed sensor in place, the service had not considered whether the person had the capacity to consent to this, whether it was in their best interest and had not re-applied for the DoLS authorisation to include this.

We found no evidence that people had been harmed however, there was a risk people's rights would not be upheld. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received training about the MCA and knew how to support people in the least restrictive way possible.
- The provider recorded evidence of people's representatives that had Lasting Power of Attorney. This gives representatives the legal authority to make decisions on a person's behalf.

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

● Nationally recognised tools for assessing people's risk of malnutrition were completed incorrectly. Care plans and risk assessments did not provide adequate guidance for staff to know how to care for people in line with legislation and evidence-based guidance to achieve effective outcomes.

● People's physical, social and wellbeing needs were holistically assessed before moving to the service. This ensured information relating to their culture, religion, likes, dislikes and preferences were included in their care plans.

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

● Care plans did not always reflect people's dietary requirements such as the nutrition people needed when they were at risk of not eating or drinking enough, or supplements prescribed. However, we found staff to be knowledgeable of these needs.

● People chose where they wished to eat their meals and were supported by staff that knew their food preferences and dietary requirements. We observed mealtimes to be a relaxed and sociable occasion.

● People had a choice of meals. One person said, "You have a choice of food at every meal." Another person had liaised with the chef to develop their own personalised menu. We received positive feedback about the food and saw people access snacks and drinks throughout our inspection.

Staff support: induction, training, skills and experience

● Staff did not always have the skills and experience to meet the needs of people living in the home. Staff had recently undertaken positive behavioural support training. However, staff had not had training to safely manage violent situations. This meant staff did not know how to keep themselves safe.

●Training was not always effective. Staff did not know how to complete malnutrition risk assessments and failed to identify incidents of abuse which were not reported.

● Staff undertook an induction, including shadowing more experienced staff. One staff member said, "I had to have 'moving and handling' done before I could do anything, I could only shadow, I was not allowed to use the hoist [lifting equipment]. If I doubled up staff took the lead and showed me."

● Staff told us they had regular supervisions and felt supported by the management team. Records showed appraisals had been recently undertaken.

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

● Care plans for people's oral care needs, did not contain enough information to guide staff how to support people with their oral care. For example, one person's care plan stated, 'assist with teeth', it did not tell staff what assistance the person needed.

● Staff told us they received a detailed handover before they started their shift. However, we found handover records contained minimal information should staff miss this handover. For example, the record for one person advised, 'Physio came.' There was no further information as to what the physiotherapist had visited for or the outcome of their visit.

● Staff knew people well and recognised when people needed healthcare support. Records showed referrals to healthcare professionals had been made. A person said, "If you are not well, staff look out for you. They'll come and check on you later. They would call the doctor if you needed it." A visiting professional told us, "They always contact us when we are needed."

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

● Some people's bedrooms had been decorated and the provider had an improvement plan in place to enhance the environment. However, some of the timescales for redecoration were up to 12 months. A person said, "The environment needs a bit of updating. A bit of painting." A relative said, "When we came a

year ago, they [service] were beginning to decorate, but it's like everything stopped. It needs work." Several windows were smeared, one person said, "I'd like them to clean the windows."

● There were several areas within the service, people could spend time in private or with their visitors and there was an accessible garden space for people to use when they wished to.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always protected. Records showed staff had not always respected people's right to express their sexuality in private.
- We identified language in some care records that was not caring. For example, referring to one person as, 'an old man'. We discussed this with the registered manager who told us they had identified this as an area for improvement and this had been addressed through recent positive behaviour support training.
- We observed staff knocking on people's bedroom doors and seeking permission to enter.
- People told us they were supported by staff that were kind and caring and we observed kind and caring interactions between staff and people. A relative told us, "They [staff] all have a laugh and a joke with [relative]." Another relative said, "All the staff are lovely." We observed staff supporting a person to mobilise in a caring and compassionate way. The person had experienced a change in their skills and abilities and were anxious and confused about using equipment. Staff took time to provide reassurance and acknowledge their feelings.
- People's cultural and religious needs were detailed in their care plans, and staff gave examples of how they supported people to practice their faith. People were empowered to be independent, we saw people coming and going throughout our inspection.

Supporting people to express their views and be involved in making decisions about their care

- Care and support plans were not reviewed with people, and residents and relatives' meetings had not been undertaken for six months. This meant opportunities for people to express their views and make decisions about their care had been missed.
- Staff told us they offered people choices such as what they wished to wear, where they wished to spend their time and what food they would like. A staff member said, "People can get up when they want, it's their choice as at the end of the day, it's their home."
- The provider understood when people needed the support of an advocate. This is someone that can help a person speak up to ensure their voice is heard on issues important to them. The service told us, if needed, they would refer people to the appropriate service to ensure advocacy support was provided. Advocacy information was displayed in the service.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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

- The service were transferring paper-based care records to an electronic system. Some staff did not have access to the electronic records and did not know where people's up to date record was held. This put people at risk of receiving care that was not in line with their current needs. One staff member said, "We need all care plans in one place, between paper and electronic care plans and who has what, we get them confused."
- Some people displayed behaviour that could challenge staff. Staff responses to these behaviours were inconsistent. For example, a person threatened to strangle staff and were given a sedative medicine to help them calm. Records showed, during similar situations some staff gave medicines and others used distraction techniques. There was a lack of clear guidance for staff to follow on how to consistently respond to this behaviour. This placed people at risk of not being supported in a way that met their needs.
- Daily records were not reviewed to determine what worked well for people to inform their care plan. Staff and the registered manager told us some staff's approach worked better than others, the learning had not been shared to improve people's care experience. People were not involved in monthly reviews of their care records to ensure their needs and preferences were met.
- People's care plans instructed staff to encourage people to participate in activities to 'keep occupied and help prevent outbursts.' However, staff did not always have time to do so. A staff member said, "Staff are caring but the residents don't get enough time with staff to spend time chatting, that would really benefit them. Staff are busy doing care."
- During our inspection we observed people to spend long periods of time unoccupied. A person said, "Staff are too busy doing things to talk to you. They are there if you need them." Another said, "There is not a lot to do because staff don't have time to do things with you." We received feedback from staff they had limited time to spend with people carrying out activities. One staff member said, "People get bored, they need more activity."
- During our inspection we raised concerns about the level of care one person received. Their level of care was increased so they always had a member of staff with them. However, the provider had not provided adequate guidance to staff, so they knew how to effectively support the person.

We found no evidence that people had been harmed however, people did not receive appropriate care that met their needs and preferences. This was a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's relationships with their families were promoted. There were no restrictions on visiting. Relatives

told us they were welcomed and gave positive feedback regarding communication. A relative said, "You can definitely talk to the staff and they call [relative] if there's any problems." Another relative said, "Staff make me feel very welcome."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were included in their care plans. However, information was limited. The registered manager told us information would be provided in 'easy read' if this was needed.

Improving care quality in response to complaints or concerns
● The provider had a policy and procedure in place to manage complaints. Complaints information was displayed in the home. However, this was behind an open door making it difficult to see, it was not available in an easy read format. We discussed this with the registered manager who told us, they would develop and display an easy read complaints procedure for people living at the service.
● There had been one complaint in the last year. This had been managed in line with the complaint's procedure.
● People and their relatives told us, should they have any concerns they would not hesitate to raise these with the management team and felt confident they would be resolved. One person said, "I don't like to complain. But if I did complain, I think they would listen because it would be serious if I complained." Another person said, "No complaints about here. If you want something, you ask."

End of life care and support
● People's preferences and wishes for the support, they wished to receive at the end of their lives was not always detailed in their care records.
● Where people had a 'do not attempt cardiopulmonary resuscitation' order and funeral arrangements, this information was available for staff in the event of a medical emergency.

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 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- The provider displayed their vision in a communal area. They did not meet their vision of, 'Learning when things go wrong and putting people and their individual needs first.' People were at risk of receiving unsafe care as records were not reviewed to identify reportable incidents. People's risk assessments and care plans were not always reviewed following incidents and adequate measures were not implemented to ensure people were protected against the risk of being harmed. Opportunities to learn from incidents had been missed.
- Quality assurance systems and processes failed to identify there were repeated incidents of assaults to people and staff, and a risk to visiting children of being at risk of harm from people's behaviour. Therefore, no action had been taken to mitigate against these risks.
- Staff did not have time to read people's care plans. One staff member said, "We don't have time to read people's care plans." Another staff member said, "The days are that busy to find time to spend with people, let alone read care plans."
- Staff did not know where to find the most current information about people's care needs as information was held in differing places. Not all staff were able to access people's care plans that were electronically held. Staff were reliant on their individual knowledge of people and handovers to keep informed of people's changing needs. We found paper-based records had been reviewed instead of the newly updated electronic records in some cases.
- The registered manager was not always present at the service. This meant they had a lack of oversight of the service and were not familiar with people's current needs. Since October 2019 there had been two interim managers, with a new manager commencing during our inspection. There had been inconsistent leadership at the service which led to the failures identified during the inspection. Team leaders were undertaking additional tasks such as submitting CQC notifications without the skills or competence to do so. A staff member told us the team leaders were "Practically managing the home" in the absence of the registered manager.
- Timely action had not been taken to address environmental concerns identified by the service. It was identified nearly two years ago bathroom flooring needed replacing, this had not been undertaken. A person's carpet needed replacing as it smelt of urine. The timeframe for replacement was 12 months. Staff told us a downstairs bath had not been working since 2017, damp spots on the ceilings had been there a long time and the home looked, "Shabby". Six high risk actions had not been completed by the action date in a fire risk assessment. This included ensuring fire-fighting equipment was correctly located.

People had been harmed or were at risk of harm as systems and processes were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and provider did not understand the regulatory requirements regarding Submitting legally required notifications to the Care Quality Commission (CQC). They had not notified us of several DoLS outcomes, incidents or allegations of abuse and police incidents.

This is a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

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's systems and processes failed to identify incidents when things went wrong which meant they had not always exercised their responsibility under duty of candour. For example, when incidents of abuse had occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others
● The provider used an online website to collate people's feedback. We saw feedback had not been provided since 30 October 2018. Residents and relative's meetings were held by the activities co-ordinator but had not been undertaken quarterly as planned due to staff absence. The last meeting took place in September 2019. People and relatives did not have the opportunity to provide feedback about their care experience, for the service to make improvements.
● A staff member told us staff meetings used to be monthly. Records showed it had been three months since the last staff meeting, and five months since the last housekeeper meeting.
● The provider had an action plan with the local authority. We found in October 2019 the local authority had identified an incident of abuse within care records that had not been identified by the registered manager or referred to safeguarding. The service failed to learn from this incident as we found the same concerns.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive appropriate care that met their needs and preferences.

The enforcement action we took:

We took urgent action to restrict admissions and imposed conditions around training, care plans and risk assessments.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a risk people's rights would not be upheld.

The enforcement action we took:

We took urgent action to restrict admissions and imposed conditions around training, care plans and risk assessments.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured all the relevant information was in place and that potential risks to people had been identified. Therefore, people were at risk of harm.

The enforcement action we took:

We took urgent action to restrict admissions and imposed conditions around training, care plans and risk assessments.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that people were protected from abuse and improper treatment.

The enforcement action we took:

We took urgent action to restrict admissions and imposed conditions around training, care plans and risk assessments.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People had been harmed or were at risk of harm as systems and processes were either not in place or robust enough to demonstrate safety was effectively managed.

The enforcement action we took:

We took urgent action to restrict admissions and imposed conditions around training, care plans and risk assessments.