Ladymead Care Home Limited

Ladymead Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ladymead Care Home is a residential care home that provides nursing and personal care for up to 27 people. People have a range of care and support needs including diabetes, Parkinson's disease; some people were living with dementia.

Ladymead Care Home is a detached house and has been adapted over two floors. At the time of our inspection 16 people were living at the service.

People's experience of using this service and what we found
People were not always protected from avoidable harm because the provider did not have effective procedures in place to make sure people were safe. Incidents were not always responded to or reported to the appropriate authority. Action was not always taken to mitigate the risk of harm to people. Infection control systems were not well managed, and this put people at risk. Medicines were not always administered in line with the prescriber's requirements.

Risks to people's health and wellbeing were not consistently managed. Processes were not in place to ensure support plans and risk assessments contain detailed and person-centred information to accurately reflect the needs of people and mitigate identified risk.

There were no adequate processes or assessing and monitoring the quality of the services provided and that records were accurate and complete. People's care risk assessments lacked important detail to guide staff on how to keep people safe.

The delivery and planning of care was not consistently person centred and did not always promote good outcomes for people. Support plans did not contain detailed and person-centred information and therefore these did not always accurately reflect the needs of those who used the service. Staffing levels were not sufficient in meeting people's wellbeing needs in a person-centred way. Staff did not have time to sit and chat with people.

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.

People and their relatives told us that they felt safe at the service.

People were cared for by staff who were kind and compassionate. The provider carried out checks before staff commenced employment to ensure their suitability to work with people. People received support from a consistent staff team who knew them well.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 26 October 2020) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when they would improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

The service remains rated Requires Improvement. This service has been rated Requires Improvement for the last four consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about infection control, medicines management, records, staffing and the overall management of the service. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. 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 providing safe care and treatment, medicines, protecting people from abuse and avoidable harm and the overall governance and management of the service including reporting of information.

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
After the inspection we wrote to the provider about some of the urgent concerns found during inspection. The provider sent an action plan that informed us of the immediate actions they had taken to address our concerns.

We will request an action plan from the provider to understand what they will do to improve the standards

of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led section below.

Ladymead 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.

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

Inspection team
The inspection was undertaken by three inspectors. Two inspectors visited Ladymead on 7 January 2021 and one inspector sought feedback from relatives and visitors to the service over the telephone.

Service and service type
Ladymead 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 last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, registered nurse, care workers, and ancillary staff. We reviewed a range of records. This included 12 people's care records and multiple medication records. A variety of records relating to the management of the service, including policies, recruitment and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We sought assurances from the provider about action they had taken to address some of the more serious concerns we had found at inspection.

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.

Preventing and controlling infection

● We were not assured the provider was meeting shielding and social distancing rules. Daily records stated a person who was known to have COVID-19 mixed with four other people in the communal lounge on more than one occasion over the Christmas period. Before Christmas other people in the lounge had tested negative for the virus. Two of the four people tested positive for COVID-19 at their next test. Isolation rules had not been followed in this instance, putting people at increased risk of contracting coronavirus. After the inspection CQC raised this as a safeguarding concern to the local authority.

● The service had failed to robustly consider the risks posed by COVID-19 towards people using the service. There was a failure to ensure robust isolation processes for infected people. We observed one person with the virus being nursed with their bedroom door open. This person was also using a portable fan heater to heat their room due to a boiler breakdown, although this was repaired during the inspection. Risks associated with the transmission of the virus through the use of portable fan heaters and open doors had not been considered. Following feedback to the provider this risk was addressed.

● We were not assured the provider was using personal protective equipment (PPE) effectively and safely. Information was provided to CQC before the inspection regarding some staff failing to wear the correct PPE. At inspection we observed some staff failing to follow PPE best practice guidance. Signage was in place to advise anyone entering the service to wear a facemask. We observed some staff entering the service without wearing facemasks. We also observed staff using the staff room and offices without wearing facemasks including when other staff were present. On one occasion we observed an agency carer enter the bedroom of a person who had COVID-19 without wearing PPE in line with government guidance. This put the agency carer at risk of contracting and spreading the virus to others. We fed this back to the provider who took immediate action to address our concerns directly with the staff team.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Housekeeping staff were undertaking cleaning of the service; however, cleaning schedules had not been amended to reflect an enhanced level of cleaning during the global pandemic of COVID-19 and recent outbreak of the virus within the service. COVID-19 disinfecting schedules were not in place and there was no schedule to evidence enhanced sanitation of frequently touched high risk areas. The records we reviewed showed several missed signatures, indicating some areas of the home may not have been sanitised on some dates. There was no evidence of cleaning and sanitisation taking place during the evening and at night. At inspection the registered manager informed us they would undertake an urgent review and update of cleaning schedules and implement a monitoring system to ensure the required level of cleaning was undertaken.

● We were not assured that the provider's infection prevention and control policy was up to date. The policy had not been updated in response to COVID-19. A separate policy was in place specifically for COVID-19,

however, this did not reflect government guidance on isolation. Guidance produced by the UK Infection Prevention and Control cell, PHE and Department of Health and Social Care (DHSC) recommends that the isolation period for resident and patient contacts in care homes should be at 14 days. This is because vulnerability to serious COVID-19 illness increases with age, and those aged 70 or over are considered at moderate risk.

● The provider told us that the current outbreak within the service was being managed by people isolating in their bedrooms for 14 days. During the inspection we observed one person sitting in the communal lounge. We also observed an agency staff member take a person into another person's bedroom so they could have a chat. There was a lack of consistency between what we were told and what we had observed. The practices we observed in the service were not in line with government guidance and placed people at risk of contracting the virus. The provider's COVID-19 policy did not provide guidance on people who were self-isolating. We requested additional documentation to review in relation to isolating people however this was not received. Following the inspection, the provider told us they would review and update their infection control policy in light of the global pandemic and their COVID-19 policy to reflect people self-isolating.

The service had failed to ensure appropriate infection control measures in response to the COVID-19 pandemic. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was preventing visitors from catching and spreading infections. On arrival a member of staff carried out a temperature check which was recorded. Visitors to the service were asked to undertake a lateral flow test to establish they were negative for the virus. PPE including face masks and visors were supplied to visitors. At inspection a contractor working on the heating system had undertaken a lateral flow test and was wearing the correct PPE. Visiting by relatives took place in a conservatory and was accessed by a separate entrance which meant they did not enter the main part of the building. Visitors told us they felt safe visiting during the pandemic because of the measures the provider had put in place.

● We were assured that the provider was admitting people safely to the service. The registered manager provided verbal assurances regarding the current approach to admissions. This included a negative COVID-19 test prior to a person being admitted to the home and a 14-day isolation period, even if the test result was negative.

Assessing risk, safety monitoring and management

● Risks to people were not identified and managed. A person who had a history of seizures prior to admission did not have a seizure risk assessment or care plan in place. Guidance was not available to ensure staff provided the person with safe and appropriate seizure care and management. Incident records showed that on three occasions since November the person had been found on the floor. Seizure activity had not been considered as a possible cause. Some of the staff did not know the person had a history of seizures and this lack of knowledge placed the person at risk of harm. We asked the provider to take urgent action to address the concerns we had raised. We raised this as a safeguarding concern to the local authority.

● Where care plans identified a known risk, records were not always sufficient to ensure safe care. For example, the care plan for a person with diabetes did not contain sufficient information to ensure the person's diabetes was managed and monitored safely. It failed to provide guidance to staff to recognise changes in the person's blood sugar levels or the action to take. There was risk that staff could miss the signs that the person needed immediate assistance to prevent a rapid deterioration in their health. The same person had a skin wound and there had been a failure to implement a detailed treatment plan for this. There was a delay in seeking advice and the skin around the wound developed infection that required

treatment by prescribed antibiotics. Where the needs summary for another person recorded, they had failing eyesight, this information had not been reflected within their care plans. Shortly after their admission to the service an incident report recorded the person crawling around the hallway after becoming disorientated in their bedroom. Risks associated with their failing eyesight had not been assessed or mitigated on admission and exposed the person to the risk of avoidable harm.

● People who were dependant on staff for their hydration needs were at risk from dehydration and urinary tract infections (UTI) as fluid monitoring was not recorded. Where it was known a person experienced repeated UTIs their fluid intake was not monitored. This included the absence of fluid monitoring when they were receiving prescribed treatment for a diagnosed UTI. The same person's care notes showed a urine test was not taken until two days after it was first considered they may have a UTI. This resulted in the person suffering effects of ill health due to a delay in the person receiving prescribed treatment.

● People's injuries were not being accurately recorded to ensure effective oversight and monitoring. For one person an incident report following a fall records they sustained a bump to their head. However, their daily record stated that they sustained no injures in the fall. There was no evidence that increased monitoring following a head injury had been implemented. For another person an incident report recorded a fall where they sustained an injury. This was not reflected in the hand over notes until five days later when the wound was cleaned and photographed. Processes were not in place to ensure people received appropriate care and treatment following accidents or when sustaining injuries. Consideration had not been given to the potential risk of head injuries being life threatening.

● Since the last inspection care plans had been transferred to an electronic care record (ECR). Staff informed us they did not feel confident or competent to use the electronic system and there were multiple examples where people's daily records were inaccurate or incomplete. Rather than accessing people's ECR to learn of changes in people's care needs, staff told us they relied on verbal updates between each other and handover records. One nurse told us they used handwritten notes and verbal feedback to handover clinical updates to nurses coming on duty rather than using the ECR. Agency staff did not have access to the ECR and were unable to directly access people's care plans and daily notes. This placed people at risk of not receiving appropriate or safe care and treatment because staff may not have been aware of people's current health or support needs.

The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes were not in place to protect people from the risk of abuse. A review of people's incident records and daily notes showed there had been a failure to consider some injuries in line with safeguarding guidance. For example, one person had sustained bruising and a skin tear whilst receiving personal care provided by staff. Another person sustained a bruise to their head when a staff member opened the door which hit their head. There was no evidence of exploration surrounding these injures including the practices of staff at the time the injuries were sustained to prevent similar incidents from reoccurring.

● After the inspection CQC raised six concerns to the local authority for consideration in line with their safeguarding adults guidance. These were about practices relating to infection control and safe care and treatment that had not been identified by the registered manager as potential safeguarding concerns. CQC were notified by the local authority that all six concerns met their threshold to progress to a section 42 enquiry. This means the concerns will be investigated.

The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were

protected from abuse and improper treatment. This was a breach of regulation 13 (safeguarding people from abuse and improper treatment)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safeguarding training was completed by new staff during induction and there was a system to ensure staff undertook refresher training. Staff had an awareness of the signs indicating a person might be vulnerable to abuse. Staff understood their responsibilities for reporting concerns. A member of staff told us they would report any concerns they had immediately to the most senior person on duty.
● People and their relatives told us that they felt safe. One relative told us that they had never had cause to be worried about their loved one's safety. Another told us that as they had been unable to visit the service due to the global pandemic; they had to rely on the registered manager and staff to keep their loved one safe. They had no reason to suggest this had not been the case.

Using medicines safely
● At the previous two inspections the provider had been asked to make improvements to ensure medicines were managed safely. At this inspection not enough improvement had been made and further improvements were required to ensure medicines were managed in a safe way. For example, at the previous inspection the reason for giving 'as and when required' (PRN) medicines and the effect had not been recorded on the reverse of the medication administration records (MAR). At this inspection there continued to be a failure to provide this information. There was a continued risk medicines and their effects were not being monitored effectively, and this had the potential to cause harm and avoidable discomfort to the person.
● Medicine protocols were not robust. Prior to the inspection we had received information that people may not be receiving medicine in line with the prescriber's instructions. Medicines were administered by registered nurses. We reviewed six people's MARs and found errors in each that had the potential to place people at risk of not receiving their medicines as intended by the prescriber. For example, a person's PRN protocol had very clear directions of when the medicine should be given. A review of this person's MARs and care records evidenced they had received the PRN medicine on three occasions, but only on one occasion was this in line with PRN guidance. On the other two occasions the medicine was used to treat insomnia which was not its prescribed intended purpose.
● MARs were not always completed correctly, and there were errors in medicine counts that had not been explored. There were duplicate signing records for each PRN medicine and staff were required to check and sign both before and after administering PRN medicine. There was a potential risk of people receiving a second dose of the same medicines if staff failed to record information simultaneously on both records.
● We viewed three people's PRN signing sheets and found discrepancies in all three. For example, one person's MAR for pain relief showed it had been signed as being administered on three occasions over a ten-day period, however their duplicate signing sheet attached to their PRN protocol showed the medicine had been administered on six occasions during the same period. The medication count for this medicine did not correspond with either figure and was in line with the medicine being administered on eight occasions during the same ten-day period. These discrepancies had not been identified or explored. After the inspection the provider arranged for nurses to undertake additional medicines training.

There was a continued failure to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicine profiles were in place and information included the level of support people required and what aspects they were able to manage independently. We observed one person operating their own inhaler and

nasal spray and this was in line with their medicine profile.
● Medicines were stored in line with safety guidance. There were processes in place for ordering and disposal. Correct processes were followed for the safe storage and administration of controlled medicines.

Learning lessons when things go wrong
● The provider had not always learnt from themes or incidents that had occurred within the service. There was a lack of robust analysis of incident and accident records to identify themes and drive service improvement. There were inaccuracies and inconsistencies between incident reports and people's daily notes. In some instances, this had led to a failure by staff to sufficiently monitor people to help identify any changes or deterioration in their health.
● We reviewed incidents and accident records and daily notes of eight people. Not enough action had been taken to minimise risks when people were assessed as being at increased risk of falls. The incident record for one person who had sustained a number of falls recorded the need to refer the person to the falls management team for advice and guidance on how to minimise falls. At inspection the provider was unable to evidence that a referral to the falls prevention team had been made for this person. Incident records showed the person continued to be at risk of falls and had sustained a further fall since the referral to the falls clinic had been considered.
● People were at risk of repeated injuries because records did not identify the root cause and enable preventative measures to be taken. We identified reoccurring themes that were not addressed or explored. The provider's monthly audit of incident and accident reports failed to evidence a robust process for exploring factors that may have contributed to an incident occurring such as underlying health conditions, medicines or environmental factors. There was a failure to evidence the outcome of these audits had been used to drive improvements and mitigate further risks to people.

Staffing and recruitment
● There were safe systems and processes for the recruitment of staff. The service followed safe recruitment processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references.
● Our observations were there were enough staff on duty to meet people's personal care needs. Staff were observed to be busy with the majority of time spent meeting people's personal care needs and supporting people to eat and drink. There was no capacity for staff to engage in activities with people whilst they remained in their bedrooms. Staff were observed to be caring, compassionate and kind in their approach and people confirmed this was also their experience.
● People told us there were not enough staff to provide them with meaningful stimulation or engagement. This was particularly prominent during the outbreak of COVID-19 in the service during which time people had been asked to remain in their bedrooms. People said staff were kind but always busy and did not have the time to sit and chat with them. One person said, "I am fed up of being in these four walls, there is absolutely nothing to do, I am going out of my mind with boredom". Another said, "I can't tell you the last time the girls had time to sit and chat, unless it is time for a drink or medicines, you don't really see anyone, it's just so lonely". People also told us they felt a heightened sense of loneliness and isolation since visitors had been restricted and felt the registered manager had not taken measures to address this.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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.

At our last inspection in August 2020 the provider's quality assurance system needed to be further developed to identify areas for improvement and fully embed these into practice. This was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and there was a continued breach of this regulation.

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

- At the last inspection in August 2020 quality assurance systems did not identify some of the shortfalls found at inspection in relation to medicines, infection control and prevention and pressure area management. At this inspection there had been a continued failure of the provider's quality assurance processes to identify concerns. This included continued concerns identified with processes to manage infection control and medicines.
- At the last inspection the registered manager acknowledged improvements to the medicines audit were required. At this inspection improvements had not been made and there had been a continued failure to identify risks related to the safe administration of medicines. For example, the medicines audit for November 2020 undertaken by a registered nurse and registered manager had answered 'yes' to the question 'are all regular and unusual refusals explained in the care plan?' The Medication Administration Record (MAR) sheet for one person showed they had refused a prescribed medicine every day for 28 consecutive days. The reason for this was not recorded on the MAR or in the person's care plan notes. We spoke to the manager who informed us this medicine was to be given PRN and it had not been required on those dates. This was not consistent with the MAR which showed the medicine was prescribed once a day and a review of the person's care records did not reflect a change in prescription. There was a failure to monitor and record the impact on the person as a result of their refusal to take the medicine prescribed to them. This left the person at risk of potential deterioration in their health and without professional medical oversight and monitoring of the impact of not taking prescribed medicine.
- Quality processes which failed to identify risks relating to the health, safety and welfare of people had not always been assessed, monitored or mitigated. Systems were not in place to identify risks to people's health and wellbeing were being assessed and documented when people's needs, or environmental factors changed. There was a failure to ensure robust assessments for people new to the service or that information was transferred to people's care plans. Records did not provide enough guidance on how to support people appropriately and mitigate identified risk. The provider could not be assured that people's care records

reflected their ongoing needs or that staff were meeting these appropriately.
● The provider had not maintained an accurate, complete and contemporaneous record in respect of each person. We reviewed daily records of twelve people and found multiple errors across all twelve. For example, the daily notes for one person recording they had COVID-19 were also found in the records of four other people. There was a photograph of bruising and a wound to a person's leg that was duplicated in other people's care records. Frequently there were entries in daily records that had not been completed, had a different person's name on them or contained minimal information. We were unable to identify any negative impact for people from these recording errors. However, the frequency of errors and the lack of identification and oversight of these meant the provider could not be assured the information available was accurate and a true reflection of the persons needs and well-being.
● Management skills, knowledge and oversight did not foster a culture that protected people from avoidable harm. This was in part due to the lack of professional judgement and understanding shown by the senior team in relation to the local authorities safeguarding guidance and their own responsibilities within this. The provider's processes for quality checking of records and quality assurance audits had failed to identify failings in infection control which had placed people at direct risk of contracting and spreading COVID-19.

The provider had not ensured there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Processes were not in place to identify individuals at greater risk from COVID-19, such as those with diabetes or other underlying health conditions. The provider had also failed to undertake individual risk assessments with staff to identify staff members who maybe at greater risk, including those shielding, and where required documented a risk assessment.
● We identified concerns in relation to the provider's processes for testing for COVID-19. People and staff were receiving regular Polymerase Chain Reaction (PCR) testing. The government consider this to be the most accurate and reliable test for diagnosing COVID-19. The provider's processes for receiving test results did not ensure results were known or communicated to them in a timely way. For example, one person's tests results came back at 3pm on the day of inspection, however the email containing this information was not opened until the following day. This delay posed a risk to people and staff because during this time a person who had tested positive for COVID-19 had not been subject to any enhanced monitoring or infection control and staff had not used enhanced PPE. After the inspection the provider took immediate measures to address this and implement a more robust processes for receiving and communicating test results.

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
● Services that provide health and social care to people are required to inform CQC of important events that happen in the service in line with regulatory requirements. The provider had not always informed CQC of significant events in a timely way. This included a failure to notify CQC of a serious injury to a person who fractured their pelvis in a fall. Service records showed two people had received injuries involving staff that had not been reported to CQC. The failure of the provider's quality assurance processes to identify people who had been placed at risk due to poor infection control practices had also led to a failure to notify CQC. This meant we could not check that appropriate action had been taken.
● During the inspection we were made aware of a concern previously raised by staff to the registered manager. This concerned an allegation of misconduct by a member of staff towards a person. The registered manager told us they had investigated the concern thoroughly which had included speaking with

the person and interviewing staff member. The registered manager told us they had not found any evidence to substantiate the concern raised. The registered manager was unable to provide us with any documentary evidence relating to the complaint, investigation or outcome. This included a lack of recording about the allegation made and conversation with the registered manager about it. The registered manager had failed to notify CQC of this allegation of abuse or harm towards a person supported which is a statutory requirement of their registration with CQC. This meant we could not check the safety of the person or that appropriate action had been taken.

The provider had failed to notify CQC of relevant incidents that affect the health and safety and welfare of people using the service. This was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

● Relatives told us they had been assured of their loved one's well-being during the COVID-19 pandemic and felt included and informed. Relatives told us were kept informed of any changes or medical appointments by letter and phone calls.
● Records showed that when incidents had happened, families had been communicated with in a timely way. Feedback included the suggestion of a newsletter with photographs to keep up to date with the service in general and what people had been doing.

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;
● Before the inspection we received information about the management and culture of the service. During the inspection process we received further feedback from people, visitors and staff. Feedback received informed us of a feeling of disconnect between the registered manager and staff. Some staff did not always feel supported or valued by the registered manager or by the provider's processes, such as supervision or when raising concerns. The registered manager told us some staff were finding it difficult to adapt to changes in the senior team and changes to ways of working implemented to drive service improvement.
● Staff and people felt there was a lack of visible presence by the registered manager around the service with most of their time spent in the office. One person told us they had been asking to see the registered manager for several days, but they had not been to see them. During the inspection one CQC inspector asked the registered manager on two occasions to speak to a person who wanted to raise a concern. The registered manager failed to speak with the person before they went off duty and this was confirmed by the person and their daily notes. Two people told us they did not know who the registered manager was, another said, "Oh I have seen her, but I don't know her name". We received feedback from a relative and two healthcare professionals that communication with the service was poor and calls were not always returned, or information shared. We also received positive feedback about visitors 'experiences of communication with the registered manager.
● We were made aware by the provider that due to the global pandemic senior managers had not visited the service on a frequent basis. After the inspection the provider implemented a daily call between themselves and the registered manager and a weekly visit by the provider or area manager which included interviews with the staff team.
● There had been a failure by the provider to identify and address the shortcomings in the implementation of the electronic care records (ECR) system. Processes were not in place to ensure all staff had access to accurate and up to date information about people's needs and wishes. Information contained within people's daily notes had not been written in a person-centred way or reflected their personality and wellbeing. Typically, entries for a whole day centred on whether the person had received their medicines, had a wash or used the commode. Following the inspection, the provider arranged for all staff to have

refresher training in the use of ECR.

● Consideration had not been given to the impact of self-isolation on people's mental health and wellbeing. There was a lack of activities to stimulate people and provide opportunities for meaningful engagement and occupation. People repeatedly told us they were lonely, and this affected their mental wellbeing. The provider had failed to acknowledge how the constraints imposed by the national pandemic and outbreak within the service had impacted people and provision had not been made to address this.

Working in partnership with others

●The service worked in partnership with other agencies. These included healthcare services as well as local community resources. Staff were aware of the importance of working with other agencies and sought their input and advice.

● The registered manager and nurses worked professionally with external agencies such as the local authority and GP practice. People had access to a range of health care professionals. This enabled people's health needs to be assessed so they received the appropriate support to meet their continued needs

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from abuse and improper treatment.

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 The service had failed to ensure appropriate infection control measures in response to the COVID-19 pandemic. The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated There was a continued failure to ensure the proper and safe management of medicines.

The enforcement action we took:

NOP to impose positive conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The there was a continued failure to ensure there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. Accurate and contemporaneous records were not always maintained regarding people's care

The enforcement action we took:

NOP to impose positive conditions on the providers registration