SNSB Limited

Roop Cottage Nursing and Residential Home

Inspection report

Wakefield Road
Fitzwilliam
Pontefract
West Yorkshire
WF9 5AN

Tel: 01977610918

Date of inspection visit:
05 August 2021
11 August 2021

Date of publication:
18 November 2021

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
Roop Cottage is a care home providing residential and nursing care to up to 35 people. On both days of our inspection, there were 26 people living in the home.

People's experience of using this service and what we found
We found an absence of systems for managing visitors to the home during the pandemic as checks to ensure individuals were safe to enter the home were not being carried out. People and staff were not part of a regular programme of COVID-19 testing. Staff were seen not wearing PPE appropriately or not wearing it at all.

Medicines were poorly managed and systems were disorganised. Medicines were not stored safely and there was an absence of some records needed to ensure this process was safe. One person missed their morning medicines on day two of our inspection.

Care provided by staff was task based and we saw occasions where areas of the home were unsupervised. There was a lack of organisation and leadership evident throughout the inspection.

Mealtimes were not personalised to the times when people preferred them and there had been a lack of action from the provider to resolve this. We saw people waiting for two hours for their breakfast, which meant a late lunch before an early dinner.

Two people identified as a risk to each other's safety had been involved in safeguarding incidents. Despite concerns about this being raised in the staff handover, these two people spent long periods of time in each other's company.

Risks to people had not been addressed and there was an absence of lessons learned. The kitchen area was not locked and was left unsupervised at a time when pots of food and water were boiling and a knife could be accessed.

A faulty fire door leading to a flight of stairs had not been identified as a risk. Staff knowledge around the number of people living in the home and who had a choking risk varied. Knowledge around how to meet people's dietary needs was not evident.

The provider did not have an overview of which people were under a 'Do not attempt resuscitation' order, or DoLS applications and authorisations. 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 management team told us they were aware of some of these issues, but they had not addressed the

areas which needed to be prioritised. Both floors of the home lacked leadership and direction. Staff did not feel supported and said there had been a lack of communication from the management team.

Some concerns have been identified around maintaining people's privacy and dignity. People we spoke with said the staff were caring and tried their best. Relatives we spoke with were aware of the recent change of ownership and indicated they wanted to give the new provider a chance.

People engaged well with the activities programme which was run by a coordinator who shared a genuine interest in making this enjoyable for people.

We have made a recommendation about the provider supporting people to plan their end of life care needs and wishes.

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

Rating at last inspection
This service was registered with us on 30 June 2021 and this is the first inspection. The last rating for the service under the previous provider was Good, published on 3 February 2021.

Why we inspected
The inspection was prompted in part due to concerns received about infection prevention and control as well as staffing levels. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
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 the management of infection control, medicine management, risks to people, care routines not being person-centred and management oversight of the home.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan 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 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 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**

Roop Cottage Nursing and Residential 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
This inspection was carried out over two days by two inspectors. An Expert by Experience also made telephone calls to people's representatives. 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
Roop Cottage 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. However, they were absent at the time of our inspection. They and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

The provider took over day-to-day control of this care home approximately five weeks before our inspection. The nominated individual, a registered manager from a sister home and two deputy managers from the

same home were present at the time of inspection.

Notice of inspection
This inspection was unannounced.

What we did before 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. We sought feedback from the local authority and professionals who work with the service. We also contacted Healthwatch for their feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who lived in the home and 11 relatives. We also spoke with the nominated individual, the registered manager and two deputy managers of the provider's 'sister' home, two nurses, the cook, a domestic worker, an activities coordinator, a laundry assistant, the handy person and six care assistants. We also spoke with a visiting professional. 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 two people's care records in full, plus an additional care plan for specific information as well as medication records. We looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and followed up concerns around infection control 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 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
• On the first day of inspection, the provider did not have effective systems in place in response to the COVID-19 pandemic. No system of testing people, staff or visitors was in place, meaning people were placed at an increased risk of transmission of this virus. Body temperatures for all individuals in the home were not being taken on the first day of inspection. Subsequently, we saw this being done on day two.
• Staff demonstrated poor use of PPE with masks being worn under their nose, chin or not at all on occasions. Staff were not following government guidance by changing into a separate set of clothing on arriving in the home.
• Social distancing was not being maintained. During staff handovers, care workers were seen closely grouped together in a small office. Alternative areas had not been considered for these meetings.
• There was limited availability of hand gel in the home. We identified this to the provider and saw hand wash was subsequently placed along corridors. We brought this to the attention of the provider and this was later swapped with hand gel.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as government guidance around managing the ongoing pandemic was not being followed.

Assessing risk, safety monitoring and management
• Action had not been taken to reduce risks to people.
• Staff knowledge around people's choking and pressure care risks was variable. A nurse we spoke with did not identify anyone living in the home had a choking risk, whilst another nurse highlighted nine people who were affected. Following inspection, the provider gave staff a list of choking risks and support needs.
• Sluices on both floors were regularly found to be open on both days of inspection. Hot water temperature checks had not been carried out since February 2021. A locking mechanism on a fire exit door on the first floor had not been working for three weeks and posed a serious risk. When we made the provider aware of this, they adjusted the lock to secure this.
• The kitchen area was accessible to anyone in the home as this was not locked. We showed the deputy manager this room was unsupervised whilst a knife had been left out and two pots of food and water were boiling. In July 2021, incident forms we looked at showed a person exited the home through the kitchen area. Following our inspection, a keypad was fitted in this area.
• One person fell out of their wheelchair in June 2021 when they leant forward and fell on to the floor. This person was seen on inspection in an unsupervised lounge trying to get out of their wheelchair. We brought this to the attention of staff who provided assistance.

• A list of slings used to hoist people was not available in the home and there was no evidence to show a thorough examination of this equipment had been carried out.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as insufficient action had been taken to reduce risks to people.

Using medicines safely
• Medicines were not safely managed.
• On the first day of inspection, a member of staff left shift with both sets of medication room keys which delayed the medication round and this impacted on the lunchtime round.
• Staff were unaware the medication room on the first floor was unlocked during this time. We saw the medication trolley was locked, but had been left in the dining room and was not secured by a chain to the wall.
• On day two of inspection, one person's medicines could not be located with the exception of one item. These medicines were found on the afternoon of the same day. The system for booking in these medicines was not orderly as this person was found to have multiple medication records, including for the same items. The person missed their morning medicines and no one had asked for external support about this.
• We were told that paracetamol was given to one person without this being prescribed. A staff member told us this was being given as a 'homely remedy'. However, there was no record of this. Following our inspection, the medicine had been prescribed for this person.
• At the time of inspection, no PRN (as required) protocols or cream charts were in place. The provider was in the process of developing these.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to manage this were not effective and meant people did not consistently receive medicines as prescribed.

Systems and processes to safeguard people from the risk of abuse
• People and their relatives told us they felt safe living at this home.
• Two people had been identified as a risk to each other based on safeguarding incidents which had occurred between them. Staff told us these people needed to be kept apart to reduce risk. During staff handover, a nurse commented that these two people had been aggressive towards each other. On both days of our inspection, we observed these two people spending lengthy periods of time together, which included unsupervised occasions. We raised our concerns with the management team.
• On two occasions, we witnessed illegal moving and handling transfers taking place. Staff were seen drag lifting people out of armchairs by placing their arms under the arms of these people and lifting them up. We made a safeguarding alert regarding these observations.

Staffing and recruitment
• We observed care provided was task based as staff were pressured to attend to people's needs.
• One person told us, "They (staff) don't have the time to sit down with me."
• The deployment of staff was not suitably managed. We had to attract the attention of staff due to the risk of one person falling out of their wheelchair. This lounge was seen unsupervised for 45 minutes on the first day of our inspection.
• On day two of our inspection, we saw night staff left whilst all day staff were in a handover. This meant the home was completely unsupervised for four minutes, putting people at risk.
• The provider had not recruited any new staff at the time of inspection.

Learning lessons when things go wrong

• We found little evidence of improvement between both days of inspection.
• In July 2021, there was an instance where a person was able to exit the building through the kitchen. No action had been taken to reduce the risk of this happening again. We found this was still an issue at this inspection as the internal door to the kitchen was continually open and the external door was open with a fly screen which was not secure.

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.

Supporting people to eat and drink enough to maintain a balanced diet
• One person told us they had lost a lot of weight and needed a soft diet. There were no weights recorded for this person and care records did not state their dietary needs. They said their relatives were bringing food into the home as the person was not always eating the food they were served.
• We spoke with a member of kitchen staff and found they did not have a good understanding around enriching people's diets if they were at risk of weight loss. The cook told us no one had specific dietary needs. On day two of our inspection, the same staff member found a record of people's dietary needs which they were not previously aware of. For example, this showed several people needed a pureed diet.
• The provider identified that the malnutrition universal screening tool for one person had not been updated since April 2021. The provider was in the process of introducing a new MUST for each person in the home by the end of September 2021.
• The provider told us that since taking over the running of the home, they did not have access to historical weight records. However, weights had not been taken in the five weeks the provider had been running the home. Following our inspection, these weights were being recorded.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured sufficient oversight to ensure people received adequate support around their dietary needs.

• Following our inspection, the provider told us they had introduced a dietary needs folder along with relevant risk assessments.

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.

• At the time of our inspection, we found people were unlawfully restricted.
• The provider did not have an overview of DoLS and when these were due to expire and who required an application to the local authority. Following our inspection, the provider identified nine people living in the home who needed a DoLS application.
• An assessment of capacity had not been carried out for these people and staff we spoke with were unsure whether people had capacity to make their own decisions.
• We observed mixed practice around people being given day-to-day choices. For example, people were given choice around their food and drink options, but some people were not given choice around where they wanted to spend the day.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not identified people were being unlawfully restricted and mental capacity assessments had not been completed for some people.

Following inspection, the provider confirmed DoLS applications were made in early September 2021.

Adapting service, design, decoration to meet people's needs
• At the time of our inspection, some people in the home were living with dementia. There were no dementia friendly features in the home to support these people.
• On day one of our inspection, the flooring on the first floor was being replaced. By day two, this work had been completed. Following our inspection, the provider told us they had identified that the boilers need to be replaced and planned to do this in September 2021

Staff support: induction, training, skills and experience
• Training records showed most staff had received training under the previous provider. Some staff had not received recent moving and handling training, although we are aware the COVID-19 pandemic may have prevented this.
• Night staff we spoke with were critical of the lack of contact they had with the management team since taking over the home.
• No staff supervisions had taken place under the new provider. They told us they wanted to get to know the staff before conducting these meetings. In early September 2021, the provider confirmed this activity had started.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People received timely access to healthcare services.
• During the inspection, staff shared examples of where input from health professionals had been requested when people needed this.
• Care records we looked at showed people were receiving support from healthcare professionals. A GP round was regularly taking place. During handovers, staff discussed people's healthcare needs and where referrals were needed.
• During our inspection, we witnessed a physio and district nurses visiting the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care and support needs were assessed to enable up-to-date care plans to be written to show how those needs would be met. These assessments were carried out by the previous provider.

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 were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• Support around waking times and mealtimes was not person-centred and did not respect their preferences and wishes.
• On the first day of inspection, breakfast started being served on the ground floor at 09:35 and 09:49 on the first floor. On the second day of inspection, we observed one person asking for their breakfast at 07:30 and staff reassuring them they would organise this. This person did not receive their breakfast until more than two hours later.
• As a result of breakfast starting late, some people did not receive their lunch until 13:30. However, dinner started at 16:00. The provider told us they were aware of these concerns, but we saw this routine took place on both days of inspection. Following inspection, the provider said they had swapped the main meal between lunchtime and evening. However, people had not been asked for their preferences around mealtimes.
• We spoke with one person who wanted to get out of bed at 8:00am. This person was not supported to get up until later in the morning when they received assistance to have shower. They came out of the shower room after 11:30am. This person had wanted to participate in a baking activity which they missed as they had not been supported at an earlier time. The person told us, "I wanted to knock some buns out, but it's too late now."

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's did not receive person-centred care around their day-to-day routines.

• People we spoke with told us the quality of care they received from staff was good. One person told us, "I honestly can't fault the carers." Other comments about the staff included, "I have to say the carers are wonderful. They couldn't do more for you" and "They're great."
• The nature of the interactions between staff and people was seen to be positive and staff were trying to provide a positive experience for people.

Respecting and promoting people's privacy, dignity and independence
• We saw mixed practice around respecting people's dignity. People's independence was not always being promoted.
• An agency worker was seen responding to a person's underwear falling down by pulling their underwear up in the corridor. This left the person in a state of undress which a permanent member of staff subsequently

dealt with in a suitably dignified way.
• We heard a member of staff making inappropriate comments in front of the people they were commenting about. For example, one person was said to be, "Manipulative" in the lounge area by this member of staff.
• Care records we looked at did not always demonstrate an understanding of the importance of equality and Human rights in the entries made by staff. One record was discriminatory and disrespectful, stating, '[Person] doesn't wear nice clothes now due to dementia' and '[Person] talks, but does not make sense'.
• People we spoke with felt they received care which respected their privacy and dignity. We observed staff knocking on bedroom doors before entering. One person told us staff always knocked on the door and asked for permission to enter their bedroom.

Supporting people to express their views and be involved in making decisions about their care
• People were not always supported to make their own decisions.
• We observed care was task based. We observed people were moved from the first floor to the ground floor where staff were present. However, this was done without asking those people for consent. One person told us, "I choose to spend time in my room, they're always trying to get everyone downstairs in the lounge." At other times, we saw people were given choice and control.
• One person told us they felt in control of their care and said they were involved in their care planning.

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
• Care plans were focused on people's care needs, but needed developing in respect of people's history and families. For example, we did not see reference to people's interests and hobbies and their work history.
• One person's 'resident assessment form' dated 12 June 2021 stated the person was bed bound. However, we spoke with this person and found they were sat in a chair in their bedroom.
• One person's care plan contained an incorrect spelling of this person's name throughout their records.
• Following our inspection, the provider was working with the Clinical Commissioning Group (CCG) on developing their care plans.

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
• We observed a programme of activities taking place in the home.
• One person we spoke with told us they chose not to participate in group activities, but added that they were always encouraged to join in. They confirmed they received one to one support from the activities coordinator.
• We observed a ball game taking place on the first day of inspection which people visibly enjoyed. On day two, baking was taking place as well as a puzzle activity.
• The activities were well-led by a coordinator who was enthusiastic and supported people well.

Improving care quality in response to complaints or concerns
• At the time of our inspection, the provider had not received any complaints during the few weeks they had been responsible for the service.
• Information on how to complain was on display and people we spoke with knew how to complain if they were unhappy.

End of life care and support
• Care plans we looked at showed end of life care needs had been discussed, although this was a basic record of people's wishes.
• The provider confirmed that at the time of inspection, no one was in receipt of end of life care.

We recommend the provider works with relevant partners to ensure staff receive suitable training and people have well developed care plans in this area.

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 documented within their care files.
• Staff communicated with people in a variety of different ways according to their needs. For example, by speaking slower and allowing time for people to respond.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• At the time of our inspection, the provider had been in day-to-day control of the home for five weeks.
• We identified a lack of leadership as key elements of the service were missing managerial oversight. The provider accepted there were a number of issues for them to tackle. However, we found the most important elements of the service were not prioritised and action taken was reactive. For example, the provider did not have sufficient oversight of COVID-19 controls, medicine management and who had a 'Do not attempt resuscitation' instruction, which would be needed in an emergency. Oversight of people's access to potentially unsafe areas had not been considered.
• The provider was aware of the issues with the mealtimes, but had not taken steps to ask people for their preferences or by ensuring breakfasts were available shortly after people woke up.
• We identified serious concerns at this inspection which affected people's safety and the quality of care they received. For example, the lack of measures in response to the COVID-19 pandemic was highlighted. We provided feedback to the provider on two occasions on the first day of inspection and once more on the second day.
• Systems of audit were not evident in the home. The management team told us they planned to use the same framework of quality checks which they used in their 'sister' home to begin these checks following our inspection.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to assess, monitor and improve the safety of the service were not in place.

• Minor improvements had been made between day one and two of the inspection. New flooring had been laid on the floor and some changes had been made to the COVID-19 visitor protocol.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• At this inspection, we found the culture of the service meant that people had to fit in around the running of the home.
• People were not empowered to have sufficient control over their day-to-day routine. We observed people were not always in control of whereabout they spent the day or when they were able to have their meals. The management team were aware of these concerns, but action had not been taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and staff were not fully supported to be engaged with the running of the home.
• Following our inspection, we have seen evidence of meetings which have taken place with people and staff. There was little evidence of user voice in these discussions.
• Staff we spoke with on both days of our inspection felt they had not been communicated with effectively. Since our inspection, the provider told us they had commenced supervision sessions with staff.
• We saw people's ethnicity, sexuality and religion was recorded in a care plan which the provider had developed. They expected to cover people's equality characteristics in all care plans which were under review.

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
• During our inspection, we clarified with the provider that it was their responsibility to notify us if the registered manager's absence last for over 28 days. We have not received a formal notification for this event since the inspection.
• Since the provider took ownership of the home, there was evidence of incidents which had occurred that we have not formally been notified about. We have dealt with this outside the inspection process.

Working in partnership with others
• The Wakefield Clinical Commissioning Group (CCG) were scheduled to visit the home following our inspection to provide guidance around infection control and effective care planning.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and support people received around waking times and mealtimes was not person-centred and did not respect their preferences and wishes.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was as absence of COVID-19 testing and an effective system to safely manage visitors. Staff did not demonstrate the correct use of PPE. People's medicines were not safely managed. Storage arrangements were not appropriate. PRN protocols and body charts were not used and people did not consistently receive their medicines. Risks to people had not been identified and shared so staff had a consistent understanding. Areas of the home which presented a risk to people were not secure.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured sufficient oversight to ensure people received adequate support around their dietary needs. The provider had not identified people were being unlawfully restricted and mental capacity assessments had not been completed for some people. Systems to assess, monitor and improve the safety of the service were not in place or were not effective.

The enforcement action we took:

Warning notice