The Homestead (Crowthorne) Limited

# The Homestead (Crowthorne) Limited

## Inspection report

18 Heath Hill Road North
Crowthorne
Berkshire
RG45 7BX

Tel: 01344776270
Website: www.thehomestead.co.uk

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21 March 2019
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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service:

The Homestead (Crowthorne) Limited is a care home which provides personal care and support for up to 23 older people living with dementia.

The registered manager of the home had left the service at the beginning of 2019, however was still registered with the Care Quality Commission (CQC). A new manager was appointed but left on 18 March 2019 just before our inspection. We were assisted by the Nominated Individual (NI) for the service, who is also the registered provider of the service. The registered manager and registered provider are 'Registered Persons'. Registered Persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's experience of using this service:

●People did not receive a service that provided them with safe, effective and high-quality care.

●Risks to people's safety and well-being were not managed effectively and this placed people at risk of harm.

●Infection control was not always managed in an effective way.

●Incidents and accidents were not managed safely to prevent a reoccurrence.

●People's needs and preferences were not always assessed or person-centred plans developed to guide staff on how to meet people's needs.

●Staff did not always complete training in meeting people's needs and this meant people were at risk of inappropriate care and treatment.

●People were not always treated respectfully or in a way that promoted their privacy and dignity.

●Staff were not always deployed effectively.

●The service was not well-led and the governance system was not effective and did not identify the risks to the health, safety and well-being of people or drive continuous improvements.

●Complaints had not always been managed appropriately.

●Appropriate referrals were not made to the local authority in a timely way.

●We were not always notified, as required by law, of notifiable safety incidents.

●Medicines management was not always safe.

●People and their relatives told us staff were caring.
There is more information about this in the full report.

Rating at last inspection:

Good (Published on 19 July 2018).

Why we inspected:

This was a responsive inspection due to information we received of risk and concern regarding the safety and welfare of people living in the home.

Enforcement:

We have told the provider to take immediate action to address some of the concerns we found. 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. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?**

Inadequate

The service was not safe.

Details are in our Safe findings below.

**Is the service effective?**

Inadequate

The service was not always effective

Details are in our Effective findings below.

**Is the service caring?**

Inadequate

The service was not always caring.

Details are in our Caring findings below.

**Is the service responsive?**

Inadequate

The service was not always responsive.

Details are in our Responsive findings below.

**Is the service well-led?**

Inadequate

The service was not well led.

Details are in our Well led findings below.

# The Homestead (Crowthorne) Limited

**Detailed findings**

## Background to this inspection

Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

This inspection was carried out by one Inspector, two Inspection Managers, a bank Inspector and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:

The Homestead (Crowthorne) Limited is a care home which provides personal care and support for up to 23 people. People in care homes receive accommodation and nursing or personal care as 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 is set over three floors. The first floor is a dementia care specific floor. At the time of our inspection 19 people were residing in the home on the first day of the inspection and 17 people on the second day of inspection as two people had been admitted into hospital.

Notice of inspection:

This inspection was unannounced on the first day 21 March 2019 and announced for the second day 28 March 2019. The second day of inspection was announced to ensure that management presence was at the service.

What we did:

Before the inspection we reviewed information we had received about the service. This included notifications the provider had submitted to us. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with four people using the service and five relatives of people residing in the home. We observed staff with people in communal areas of the service. We spoke with the Nominated Individual, who was also the registered provider of the service, the registered manager of the service's sister home, the administrator, the chef, the kitchen assistant, two district nurses, an Occupational Therapist, housekeeping staff, seven care staff members, five local authority staff, and two fire safety inspectors. We looked at 18 people's care records and associated documents. We reviewed people's medicine administration.

We looked at the records of accidents, incidents and complaints, service user and relative feedback surveys. We also looked at staff training records for all staff, the recruitment records and the supervision and appraisal records.

Inadequate

# Is the service safe?

## Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management:

● People's risks were not managed safely and their risk assessments were not reviewed on a regular basis to ensure they were kept up to date and reflected any changing needs. The level of detail in people's risk assessments to ensure any risk was managed effectively was very limited. For example, one person was identified as being at risk of constipation. The actions and interventions section of the risk assessment was blank. The person's care plan just stated to monitor bowels and give medication as required. There were no actions around fluid and diet management. There was no bowel monitoring chart in place. This person was also identified as being underweight however they had last been weighed 3 November 2018.

●A person had been identified as being at risk of developing pressure ulcers. The care plan stated that staff should encourage the person to move. There was no detail about how often the person should be encouraged to move. There was no repositioning chart in place so we were unable to assess if this was taking place on a regular basis. The risk assessment had not been reviewed since 29 December 2018. We discussed this with the NI who told us that the registered manager from the sister home would be reviewing all of the care plans in the service. This had not been started at the time of our second day of inspection.
● One staff member explained that several people required hoisting to assist them with mobility. However, they told us that there was no hoist in the building. We asked what happened when people needed the assistance of a hoist to move or go to the toilet or shower. We were told that they were lifted under the arms. Moving a person manually where the need for a hoist has been identified is not advised as it puts people and/or staff at risk of suffering an injury. Some people were restricted to their rooms and left in their beds because it would be necessary to hoist them. When we spoke with the NI they stated that a hoist had been ordered.

The registered person failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:

●People did not always have their medicines managed in a safe way.
● We found where people have been administered medicines, staff had not always signed the associated medicine administration record (MAR) to say this had been given. There was evidence of ten people's MAR charts that had missed signatures on them over the course of a week. This meant that people were at risk of not having their correct dosage of medication.
● MAR charts did not clear identify when a medication was prescribed 'as required' (PRN) medication.

● Where people were prescribed 'as required' (PRN) medication, the service did not have protocols or guidance in place to ensure that staff knew when to administer PRN medicine. A senior member of staff stated they would know when people wanted PRN medication because, "staff would know the indications". When asked how new members of staff would know this, they stated "staff would tell other staff when they think someone wanted it". This meant that people were at risk of not having their medication when they needed it.
● Where medicines had been given, the system in place for recording this was not always effective. We did a stock take and found the amount of medicine in stock did not match that recorded by the provider. This meant that errors and omissions could not be identified in a timely way.
● On the second day of the inspection, people's morning medication was given late. There was no indication on the MAR sheets that medication had been given to people before food, which was highlighted as a requirement for some of the medication.
● Staff did not have adequate training or monitoring of their competency in medicines management. One staff member, who was administering medicines stated they had "I've had no meds training". They told us "I didn't do [medicines administration] for three days when starting, then I started to do them". They went on to state that when they expressed concerns to the previous manager they were able to shadow for a few weeks. The staff member stated they still hadn't been offered medication training.
● There was evidence that controlled medication was accurately stored and counted. We did a stock take and found the amount of medicine in stock did match that recorded by the provider.
●On the second day of inspection we were informed by a member of the Bracknell Local Authority safeguarding team, who was also present, that one person had admitted to hoarding some of their medication. They handed over the tablets they had been hoarding. Tablets included paracetamol which could an adverse effect on their health if taken all in one go. We could not be assured that staff were monitoring people taking their medicines.

The registered person failed to protect people from the risks associated with the unsafe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Preventing and controlling infection:

● People were not always protected from the risk of harm in relation to the spread of infections.
● There was an infection control audit file however the only audits we could see were of the hoist which had last been completed July 2017.The NI was unaware of any other infection control audits.
● We saw that the home was not as clean as it should be and there was a malodour present.
● One staff member stated, "Infection control does not exist. For example, a resident went to the toilet and they didn't feel they were assisted as there were faeces everywhere. A second example is where, there were faeces in the shower where a person had used this and not the toilet".
● On the first day of the inspection it was noticed that in the dining room where breakfast was going to be served the table cloths were soiled.

The registered person failed to protect people from the risks associated with the spread of infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Learning lessons when things go wrong:

● The registered provider did not ensure effective systems were in place to investigate and monitor accidents and incidents. Records of accidents and incidents lacked detail and did not evidence that any

monitoring took place of people after they had been involved in a safety incident.

●Accidents and incidents were not reviewed to look for patterns or to check that effective measures had been put into place to reduce the chance of them happening again. Investigations into incidents lacked sufficient detail which meant that opportunities to learn from them were missed.
●This meant the registered person failed to ensure, where things had gone wrong, that information was available so that lessons could be learnt to improve the safety of the service for people.

The registered person failed to suitably assess risks to the health and safety of people who received care and treatment and to do all that was reasonably practical to reduce and mitigate such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staffing and recruitment:

● Staff were not deployed effectively to ensure people always had their care needs met. For example, on day one of our inspection people were in their nightwear by 17:00 as staffing levels meant that they needed to assist people to bed before the night staff came on duty. On day two of the inspection, higher staffing levels through agency had been put in place and therefore this was not the case. A dependency tool was used to calculate the required staffing levels and this was reflected in the staffing rota and the number of care staff we saw during the inspection. During the inspection we noted that, due to recent concerns, there had been an increase in staff deployed in the home. However, we could not always be assured staff were effectively deployed to keep people safe and meet their needs.
● Staff and relatives told us there was not enough staff to ensure that people had access to the garden, community and activities as they wished. On both days of our inspection people were either in their room or sat all together in the lounge with very limited interaction between themselves and the staff. Staff told us that people were discouraged from leaving the lounge as they could monitor people more easily if they were all together.

● The registered person failed to consistently ensure that sufficient numbers of staff are deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People were not always protected from the risk of being cared for by suitable staff. Gaps in employment history was not always explored. Satisfactory evidence of conduct in employment that related to previous work in health and social care was not always obtained, for example one person had worked in a public house but also as a care worker. The reference had only been obtained from the public house. Recruitment records looked at, all contained a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people.

Systems and processes to safeguard people from the risk of abuse:

● Care staff had received some training in safeguarding vulnerable adults. Staff we spoke with were able to describe signs of potential abuse and how they would report any concerns they had. People we spoke with told us they felt safe. One person stated, "Staff are a great help. I use my frame a lot to get around". One relative commented, "Very much so, they were looked after well when [person] has had a bad chest infection".
●However, we found that appropriate referrals had not always been made to the safeguarding authority

when someone was at risk of abuse. The local authority safeguarding team confirmed this.

●We had found that allegations of abuse incidents were not always reported in a timely manner to the Care Quality Commission as required under the Regulations and we have reported on this in the well-led domain.

Inadequate

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes and was inconsistent. Regulations were not met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience:

● People could not be assured that they would be supported by sufficiently skilled and well supported staff. Staff told us that they had received some training the provider considered to be mandatory. However, the training matrix showed that most staff were not up to date with their training. The Occupational Therapist told us that they had concerns that staff did not know how to support people with certain moving and handling equipment, such as a hoist.
One staff member told us about their induction, they said that "Training was to be completed at home in your own time and you would be paid for this". When asked if there was a required time for this to be completed they stated "no". Another staff member stated when asked about fire training in the home, "I can't remember when they had a fire drill last. I was shown all of the [fire] points when first starting".
●Staff told us, and records confirmed, that they had not received one to one support from a manager in the form of supervision or appraisals. One member of staff told us "We have some training on the internet. But nowadays we don't get much training".

The registered person failed to ensure there were sufficiently competent staff who received appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

●On both days of our inspection, we observed the dining experience of people at lunchtime. It was clear from our observations that there was only one staff member there to assist people. This meant that people did not always get the timely response or assistance they needed. For example, one person asked for salt and pepper, but they never received this. One relative commented, "I've come in to cold food by [person] bed, [person] has a risk of choking and needs supervision". It was observed two people's meals were taken away and the pudding was offered without the meals being touched.

●We reviewed one person's care plan which stated that they required blended food as they had been identified as having difficulty swallowing, however we found that the care plan did not match what we observed the person being fed. The agency staff member feeding the person stated that they were not told about the person's dietary requirements. The chef was not aware of anyone requiring bended food.

●We asked people and staff about the food. One person stated, "Average there's not really a (choice), it's set menu". At the time of speaking to the person it was noticed there was no water available. A staff member spoke with us about the food and said "It's alright but sometimes it's a bit chewy and difficult for people to eat".
●People were offered some choice of food and drink. The chef told us that the menu had recently changed and now people had a choice of deserts. He also stated that if a person didn't like the food being offered they could provide them with an alternative. Chef told us that people always had access to healthy options and ensured there was always vegetables with each person's meal and fruit available.

Supporting people to live healthier lives, access healthcare services and support:

● We saw evidence in people's daily notes that referrals had been made to healthcare professionals such as GPs, dentists and chiropodists. However, a health care professional told us that some referrals were not done in a timely way, for example one person had been admitted to the service with a supra pubic catheter (this is a urinary catheter that has a tube into the abdomen) a referral had not been made to the district nurse for four weeks and this was only done when prompted by the district nurse themselves.
● One relative commented, "I've seen the district nurse recently".

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).
●Not all staff were clear about the principles of the MCA and understanding people's right to choose. When asking a staff member if they had received training in MCA they stated "no". The member of staff could not give a clear answer when discussing the principles of MCA. Records showed that MCA around specific decisions was not always in place.
●The registered person had made DoLS referrals for people who had restrictions in place in relation to their care and support. We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw where the applications were due to expire contact was made with the local DoLS team as per their procedures. However, in one case the conditions of a person's DoLs had not been met. This person should be supported to have regular access to the community. Staff told us that this was not taking place due to staffing levels.

The registered provider failed to ensure the service was working within the MCA legal framework. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

# Is the service caring?

## Our findings

People were not treated with dignity and respect. Regulations have not been met.

Respecting and promoting people's privacy, dignity and respect:

●People were not always treated with dignity and respect. During our inspection we observed at 09:30 that one person, who was mobile, had been incontinent. However, despite prompting staff on two occasions, this person was left to walk about the home and have their lunch without being supported to change. At 13:35 this person had still not been helped to change.
● One relative told us that the previous registered manager had removed a large amount of their relative's clothes and put them in bin bags in the office. This was all done without consultation with the person or their relative. On questioning the manager, they were told that their room had been 'too cluttered'. Whilst this manager has left the service we observed on inspection that all of the person's clothes remained in bin bags in the manager's office, despite the relative having made a complaint about the incident.
● People were asked if they felt staff respected their privacy and dignity and promoted their independence. One person stated, "As far as I know". One relative stated, "There is no bath, no hoist and agency are not welcoming."

The registered person failed to ensure people are treated with dignity and respect at all times. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; equality and diversity:

● We did see some positive interactions between staff and people at meals times, although there was only one staff member present during lunch.
Relatives were mainly positive about the staff and told us that they felt they were very caring.

Inadequate

# Is the service responsive?

## Our findings

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

People's needs were not always met. Regulations have not been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

● Care plans were not always person-centred and did not contain details of people's individual choices and preferences.
●We reviewed people's care records and we found care plans lacked person-centred details. Some care plans contained a 'My Life Now' chart which should detail people's specific life history and their likes and dislikes so that staff could build a picture of this person and ensure their support was personalised. However, these charts were all blank.
●Care plans we looked at lacked detail. For example, two people who were at risk of pressure ulcers had an action of 'move regularly'. There was no detail around how regularly or how they should be moved or how the outcome of the intervention should be monitored. All the care plans we looked at had not been reviewed since December 2018. This meant that we could not be reassured that people's care plans were an accurate reflection of their current needs and this also meant that any agency staff reading people's care plan would not be clear about how to best support them.
● The service had an activities coordinator. However, they were only on duty one day of the inspection. We saw little evidence of any activities taking place. People mainly sat in the lounge and slept. Staff told us that due to current staffing level they had limited time to offer activities or support people to access the garden or the community. On the first day of inspection we saw that people were in their nightwear from 17:00 and saw written evidence that staff had been instructed to take people to bed by 20:00 so that this was not left to the night staff.
● Where care plans reviews had taken place, there was no evidence that this had taken place in discussion with their person or their relatives. For example, in one file the care plan was only signed by the service.

● The registered person failed to ensure records reflected a clear care and treatment plan of people's individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The premises was not fit for purpose in its current lay out. There was a lack of the necessary equipment and support facilities to meet all people's needs.
There was not enough seating for all residents in the dining area. Due to this some people had meals in the lounge or their bedrooms.
● On the first day of inspection, it was noted that the radiators were not working. The service was using small electronic heaters in the building. It was seen that room temperatures had not been recorded from 26 November 2018 to 14 January 2019.
● On the second day of inspection we observed that the shower room on the first floor was being refurbished. We were told it was going to take 'two weeks'. When enquiring if there was another bath room, we were told this was on the second floor. On inspection of this bathroom, we saw that it was filled with

cleaning products, so much so that you could not access the end of the room.
There was a stable door to a small kitchen accessed by the ground floor. On both days of the inspection we observed that the bottom part of the door was shut with a bolt that could be easily opened from the outside. People could unlock this door and access the kitchen or could lean over and have access to it.
The service did not have a hoist to assist with moving people. We were told by staff that people were being moved manually. The Occupational Therapist (OT)undertook an assessment of those people that required the support of two people to move and concluded, that whilst it was not ideal to move people without a hoist, on balance of risk, given that they could not be assured that staff had the necessary hoist training, that this was acceptable until a hoist could be arranged and staff given the necessary training. The NI told us that a hoist had been ordered.
When undertaking a water temperature check, we found that there was no pressure to the tap and the water temperature stayed cold.
People's access to use toilets and bathrooms as they wished were significantly limited. On the first day of inspection, on the top floor, there were two toilets available for people. One of the toilets stated, "Out of order" and the second toilet was locked by a keypad. One bathroom was being refurbished as a wet room and we told would be out of action for two weeks. The other bathroom on the top floor was being used to store equipment.
The registered person failed to ensure that the premises was clean and fit for purpose and that adequate support facilities and equipment was in place This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Improving care quality in response to complaints or concerns:

● Complaints and concerns were not adequately managed and investigated. We did not see any evidence of how complaints were managed and the NI was unable to locate where complaint records were held.
A relative told us that when she made a complaint to the manager and then to the registered manager of the sister home they did not receive a response. After prompting they received an email acknowledging their complaint but with no evidence that the complaint had been investigated or any action taken.
● Most people we spoke with told us they had not made a complaint.

The registered person failed to operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

End of life care and support:

● At the time of inspection, some people were receiving end of life care. People's care records contained information that included brief detail about people's choices around their wishes in relation to resuscitation decisions and end of life care wishes. The records showed these decisions were discussed with people and, where applicable and relevant, their relatives.

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

There were widespread and significant shortfalls in service leadership. Some regulations were not met.

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 service did not have a registered manager in post. The registered manager of the home had left the service in February 2019, however was still registered with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, they are Registered Persons. Registered Persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
●The registered provider had not put any measures in place to ensure the service had adequate management support whilst they were recruiting a new manager. During the inspection, there was a senior carer present and the Nominated Individual (NI) who was also the registered provider. There was a manager from another service who was present on occasion, however they were keen to emphasize that their responsibility was with the service they were the registered manager of and could not spend any significant amount of time at The Homestead. The NI was unable to answer questions about the governance of the service. They stated that they had "trusted the manager" and that their oversight of the service had been limited to weekly reports on areas such as staff sickness. The NI stated that they were interviewing for a new manager on 2 April 2019 and in the meantime, had instructed an agency to find an interim manager.
● Relatives commented on the management and leadership of the service. One relative stated, "Management, don't know what's going up". A second relative stated about the previous manager, "Had my doubts about this [person]".
●We did not see any systems in place for monitoring and improving the service. We asked the NI for any audits of the service but they were unable to locate any.
●There was not sufficient oversight of accidents and incidents. Accidents and Incident forms had not always been completed and investigations and actions had not always been undertaken to prevent reoccurrence. Where actions were identified these had not always been followed up. At the time of inspection, we could not be assured that systems were in place to assess, monitor and improve the quality of the service being delivered to ensure they were keeping people safe.
●The provider had failed to ensure that complaints were effectively managed and to assure themselves that investigation and action was taken. The provider could not evidence that patterns and trends had been identified to understand how improvements could be made to the service, or that learning had taken place and shared with the staff group to improve performance

The registered person failed to have effective quality assurance systems which meant that they could not always continuously learn, improve and innovate. A lack of audits put people at risk of potential harm, as

areas for improvement had not been addressed to mitigate risk. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

●Services registered with Care Quality Commission (CQC) are required to notify us of significant events, of other incidents that happen in the service, without delay. The registered person had not always notified CQC of reportable events within a reasonable time frame. This meant we could not check that appropriate action had been taken to ensure people were safe.

The registered person failed to notify the Commission of notifiable events, 'without delay'. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff:

●We looked at whether people and their relatives were encouraged to give their views about the service they received. We could not find any evidence that people or relatives took part in meetings with the service to share their feedback.
● People and their relatives were asked if they had ever given feedback or comments on how the service was performing. Two people stated, "No". One relative stated, "Didn't know there was such a thing as residents/relative's meetings". A second relative stated, "Have already told them, carers do the work here".
●We saw a relative and service user survey for 2018. Most feedback was rated as 'quite satisfactory' however, where comments had been written, for example, the need to improve keeping families up to date and the lack of access to the garden for people, there was no evidence that any action had been taken as a result of the feedback.

Working in partnership with others:

● People's care plans contained records of visits or consultations with external professionals. Those seen included GPs, chiropodists and dentists.

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<br><br>The registered person failed to ensure records reflected a clear care and treatment plan of people's individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

enforcement action we took

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The registered person failed to ensure people are treated with dignity and respect at all times. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

enforcement action we took

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered provider failed to ensure the service was working within the MCA legal framework. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

**The enforcement action we took:**

enforcement action we took

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 12 HSCA RA Regulations 2014 Safe care |

| | |
|---|---|
| personal care | and treatment<br><br>The registered person failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

We took urgent action to impose conditions on the registered provider's registration to restrict them from admitting any service users to the location The Homestead (Crowthorne) Limited without the prior written agreement of the Care Quality Commission.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The registered person failed to ensure that the premises was clean and fit for purpose and that adequate support facilities and equipment was in place This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

**The enforcement action we took:**

enforcement action we took

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The registered person failed to operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

enforcement action we took

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered person failed to have effective quality assurance systems which meant that they could not always continuously learn, improve and innovate. A lack of audits put people at risk of potential harm, as areas for improvement had not been addressed to mitigate risk. This was a breach |

of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

**The enforcement action we took:**

We took urgent action to impose conditions on the registered provider's registration to restrict them from admitting any service users to the location The Homestead (Crowthorne) Limited without the prior written agreement of the Care Quality Commission.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered person failed to consistently ensure that sufficient numbers of staff are deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

We took urgent action to impose conditions on the registered provider's registration to restrict them from admitting any service users to the location The Homestead (Crowthorne) Limited without the prior written agreement of the Care Quality Commission.