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Fernica (Residential Care Home)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Fernica is a small family-run residential care home for up to 14 people living with mental health difficulties. At the time of our inspection there were six men and four women living at the home.

People's experience of using this service and what we found
The provider and registered manager did not always understand or meet all the relevant legal requirements and obligations associated with registration. The provider did not keep abreast of changes in practice, guidance and legislation.

The home had not complied with national guidance on COVID-19 infection prevention and control measures for care homes. The provider did not always recruit staff safely. The home did not have sufficient or robust staffing arrangements to prevent staff working excessive hours and to meet people's needs to access the community. The provider did not meet the recommendation from our last inspection to implement a business improvement plan to record ongoing and sustained improvement. The provider had failed to submit statutory notifications for two incidents.

The COVID-19 pandemic had imposed restrictions on people's ability to achieve maximum choice and control of their lives. The home had started to 'open up' as COVID-19 restrictions eased; some people accessed community activities but others who needed help had limited access due to staffing levels.

Staff administered medicines safely. Staff completed risk assessments and developed care plans to support people with their individual care needs. Staff recognised people's changing needs due to their health conditions, old age or frailty and took steps to address them.

People looked well. They received the healthcare they needed from other professionals such as GPs and psychiatric nurses. The service prompted people to attend to their personal care needs and supported them when required.

Staff showed a strong commitment to keeping people safe and well. They received the appropriate training and supervision to help them support people effectively. People and their friends and relatives gave mostly positive feedback about the service. They described staff as caring and attentive.

We observed good interactions between staff and people. Staff knew people well and responded to their individual needs, preferences and choices. The service met the cultural needs of people. For example, staff supported people to practice their faith, access culturally appropriate activities and eat appropriate food.

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

Rating at last inspection

The last rating for this service was Good (published 14 November 2018).

At our last inspection we recommended that findings from the audits and feedback received continued to be reflected in the home's business improvement plan along with any action taken to help demonstrate ongoing and sustained improvements. At this inspection, we found that the recommendation had not been met.

Why we inspected
We undertook a targeted inspection to look 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. This included checking the provider was meeting COVID-19 vaccination requirements.

At the inspection, we found concerns with infection control practices and governance. We widened the scope of the inspection to a full inspection looking at all five key domains. During this inspection we identified further concerns, some of which the provider attended to immediately. For example, they arranged for a service to be carried out on a person's bath chair; they updated the signatures for the medicines administration system, and they submitted two outstanding statutory notifications.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, good governance, notification of incidents, and fit and proper persons employed at this inspection. We have recommended the provider support people to avoid social isolation and access the community based on their personal preferences and needs.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was effective.	**Good**
Is the service caring? The service was caring.	**Good**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Fernica (Residential 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 team was carried out by three inspectors.

Service and service type
Fernica 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 announced. We gave a short period of notice of the inspection because the service is small, and we wanted to be sure there would be people and staff at the home to speak with us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and five relatives and friends about their experience of the care provided. We spoke with four members of staff, including the registered manager. We reviewed a range of care records for five people and three people's medication files. We looked at two staff files in relation to recruitment. We reviewed a range of records relating to the management of the service including audits and policies.

After the inspection
We continued to seek clarification from the provider to validate our evidence.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● The provider did not always recruit staff safely. One staff member's personnel records showed gaps or vague information in their application form and a lack of assurance around the authenticity of the references. A volunteer recruited in October 2021 had not had any recruitment checks.

The provider had not followed safe recruitment practices. This placed people at risk of harm. This was a breach of regulation 19 (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of our inspection, the home did not have sufficient and robust staffing arrangements. The home had a small staff team and no vacancies. However, the housekeeper had been absent from work for 12 months, and the registered manager worked excessive hours per week.

● The provider had not taken any action to address the long-term absence of the housekeeper who had worked 24 hours per week. During this time, care staff had been undertaking the housekeeping tasks, which reduced the time they had to support people, with the main impact for people being limited access to the community.

● We reviewed staffing rotas for a five-week period. These showed that the registered manager worked excessive hours and did not take enough breaks. They worked mainly in providing care, neglecting the registered manager role. They worked between 67 and 92 hours per week as well as covering three to six sleep-in shifts and the out of hours on-call rota. For example, in one week, they had worked 85 hours as well as covering three sleep-in shifts.

The provider had not ensured safe staffing arrangements. This placed people at risk of harm. This was breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The home did not have adequate infection prevention control measures in place in line with national and local guidance for care homes relating to COVID-19.

● On the first day of our inspection, we found that staff did not wear personal protective equipment (PPE). On our second day, staff wore PPE appropriately. However, we received information from the local authority that on a visit they made after our inspection, none of the staff had been wearing PPE (specifically masks).

● On the first day of our inspection, staff did not ask us for proof of vaccination or evidence of a negative lateral flow test. On our second visit, the provider checked these.

● The provider did not check if visiting professionals were fully vaccinated against COVID-19 in line with national COVID-19 guidance for care homes.

● The home did not have PPE stations; there was no PPE visible with the exception of a bottle of hand gel at

the entrance and in the dining room. There were no hand drying materials in one of the bathrooms. A sink in one of the smaller lounges did not have any hand wash or soap or drying materials. We were informed that staff turned away a visitor who had forgotten to bring a mask (rather than being offered a mask).
● On the first day of our inspection, the home showed signs of poor hygiene and cleanliness. By our second visit, most of the home was clean in line with the provider's cleaning regime.
● Staff took part in the routine COVID-19 testing programme. However, staff used lateral flow tests for routine monthly testing of people and not polymerase chain reaction (PCR) tests as required by the national whole home testing programme.
● The provider had not completed individual risk assessments for staff or people in relation to their COVID-19 risks.
● The home had an environmental COVID-19 risk assessment dated August 2021. They agreed to update it after our inspection and share a copy with us but failed to do so.
● The provider did not keep up to date with COVID-19 government guidance for care homes, which was reflected in their inconsistent practices and confusion experienced by staff, people and their friends and relatives. For example, people and their friends and relatives we spoke with were confused about the current visiting guidelines. Some people told us they could not have any visitors or go out. Other people received visitors in the home, while some met friends and relatives outdoors or in the community.

The provider had not complied with national COVID-19 guidance that set out a range of infection prevention and control measures for care homes. This placed people at risk of harm. This was a breach of regulation 12(1) and 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received training in infection prevention and control.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.

● The Government has announced its intention to change the legal requirement for mandatory vaccination of staff in care homes, but the service had not met the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19. Not all staff had received COVID-19 vaccinations. The provider could not produce evidence of medical exemption from vaccination for one of the staff.

This was a breach of Regulation 12(3), but the Government has announced its intention to change the legal requirement for vaccination in care homes.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider had systems and processes in place to safeguard people from the risk of abuse and avoidable harm. Staff received mandatory safeguarding training and knew how to recognise and report safeguarding concerns.
● Staff knew how to report accidents and incidents and the incident and accident log books we reviewed showed they recorded them fully.

Assessing risk, safety monitoring and management
● Staff assessed people's risks and took appropriate action to address them. For example, staff had arranged for one person to have a mobile pendant alarm to help manage the risks associated a serious health condition.
● The care records we reviewed had up-to-date risk assessments and care plans. We also reviewed people's

daily care logs, which staff completed fully and accurately.
● The home had an environmental risk assessment, which identified potential risks in the home and showed the actions required to mitigate them. This included the risk of slips and trips and risks from hazardous substances, hot water, cooker, furnishings, bath seats and stairs.
● The provider made sure most servicing of the premises and equipment took place at the appropriate time. However, we noticed that a person's bath chair last had an annual service in October 2020. The home rectified this oversight immediately by scheduling a service.

Using medicines safely
● Staff administered medicines safely. The provider ensured safe storage, stock control, administration and disposal. However, one of the cupboards that held people's medicines was cluttered, which increased the potential risk of medicine errors.
● We reviewed four people's medicines records, which staff had completed fully and accurately. For example, one record clearly showed that a person had continually refused to take their medication and the subsequent escalation of this to their doctor.

Good

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 our last inspection we rated this key question Good. At this inspection, the rating for this key question has remained Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- Staff assessed people's individual needs and determined if they could meet their needs safely and effectively. They recognised people's changing needs due to their health conditions, old age or frailty. They referred people to the appropriate health and social care services if they identified additional or unmet needs.
- The care records we reviewed showed up-to-date assessments with individual care plans for people's identified care needs, for example, personal hygiene, medicines, and physical health.
- The staff team shared information about people, appointments and any issues and concerns at handovers. They also used communication books and daily records to record up-to-date information.
- The service had a robust admissions process that involved a review of referral information, a request for further information if needed, transition planning and visits, and a review period that allowed the service and the person to assess the suitability of the placement.

Staff support: induction, training, skills and experience

- Staff completed a full induction and mandatory training when they commenced employment. Mandatory training included courses on the Mental Capacity Act, nutrition, managing aggression, medication, fire safety, and health and safety. Staff received annual reassessments of their medication competencies.
- Staff received regular supervision that focused mainly on day to day tasks. We discussed how these could be enhanced to include staff learning and wellbeing. Staff received annual appraisals during which staff could identify their learning needs but there was no information to indicate if these had been followed up.
- The staff we spoke with said they were adequately trained. They described managers as supportive and said communication was very good with staff kept informed of any changes.

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

- Staff supported people to maintain a balanced diet. The provider offered a menu that was rotated every four weeks. Staff made adjustments to the menu as needed, for example, due to people's preferences and to take into account birthday celebrations. Staff monitored people's weight regularly and escalated any concerns to local health professionals if needed.

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

- The service worked closely with a wide range of health and social care services such as GPs, practice nurses, district nurses, community psychiatric nurses, specialist nurses and social workers to ensure people

received the right care at the right time.
● People looked healthy and well kempt. People received annual health checks. Staff monitored people's physical and mental health closely and recorded their observations, for example, weight and mood. People had access to services such as podiatry and dentistry to support their health and wellbeing.

Adapting service, design, decoration to meet people's needs
● The provider had adapted the home to meet people's needs. The home was based in two adjoining houses located in a residential area. People had single bedrooms located over three floors (including the basement) and access to shared facilities such as lounges, a dining room and gardens.
● Some people's bedrooms were in the basement. People accessed the basement via a narrow staircase with a low ceiling, which meant they had to bow their heads to avoid injury.
● The basement had sensor lights that activated when reaching the bottom of the stairs. However, there was a slight delay, which presented a risk of trips and falls. We mentioned this to the provider who said they would adjust the setting.
● The care home had a good standard of décor and furnishings in most of the home but the basement living area had a tired state of décor. The provider had plans to refurbish some of the facilities such as an empty bedroom, two bathrooms, the staircase carpet and an outdoor shed.
● During our inspection, the communal areas felt very cold. We saw some people wearing coats in the house but they did not complain about the temperature. We mentioned this to the registered manager who explained that some rooms were not heated as they were not used very often.
● The home had handrails and anti-slip mats in place where needed. The provider had helped a person with specific needs and risks to install a bath chair to enable a person and risks to remain at the home safely. They had also obtained wheelchairs for two people for outdoor use.

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

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

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

● Staff had received training on the Mental Capacity Act (MCA) and understood the principles of the MCA. Staff assessed people's capacity for making decisions in line with the MCA and in their best interests.
● The provider submitted appropriate applications to the local authority when they needed to deprive people of their liberty to keep them safe.

Good

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 our last inspection we rated this key question Good. At this inspection the rating for this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- Staff treated people well. We observed good interactions between staff and people. Staff knew people well and responded to their individual needs, preferences and choices.
- Staff supported people to practise their religions. For example, they met people's dietary preferences and arranged for a local rabbi to visit.
- The people we spoke with gave positive feedback about the service and staff. One person told us, "It's like a big family."
- People's relatives and friends spoke highly of the standard of care people received. One relative told us, "They are caring, ... [person] is treated well, taken care of." Another said, "No concerns about the care, [person] seems happy." Another said, "[Person] loves it, well fed, well looked after, always well kempt, staff are attentive."

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

- Staff used various methods to obtain people's views about their care. Staff talked to people about their care on a day-to-day basis. Staff held residents' meetings with people every two-three months. Staff completed annual 'All About Me' reviews, which invited people to share their views and aspirations.
- Some people had advocates and solicitors involved in their care.

Respecting and promoting people's privacy, dignity and independence

- The service helped people maintain their daily living skills. For example, people able to do so helped with daily living activities around the house such as laundry. One person told us, "I get out a bit, have little jobs in the home, go for papers and walks."
- Staff prompted people to attend to their personal care needs and provided personal care if needed, for example, if a person had a risk of self-neglect when their mental health declined.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. At this inspection, the rating for this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

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

● Prior to the pandemic, people had enjoyed a lot of access to the community. During the pandemic, people experienced a loss of activities, community access, and contact with friends and relatives. Some people and some friends and relatives told us that they felt the home had been too restrictive during the pandemic and had delayed in 'opening up' as restrictions eased. For example, one relative told us, "they won't let [person] out." Another relative said, "[Person] is not allowed to come and go", and one relative told us that the home "can be a little strict." They described the negative impact this had had on people.

● At the time of our second visit, the home had started to 'open up'. One person attended college. Some people went out on their own locally. Some relatives and friends visited the home or met their loved ones outdoors. Several other people met family and friends either at the home or in community settings.

● People continued to express confusion about whether they could go out or have visitors in the home, and this view was shared by the friends and relatives we spoke with. We discussed this with the provider, who said that they would provide an update.

● At the time of our inspection, the staff team covered cleaning duties for up to 24 hours per week due to the absence of domestic staff. Although staff encouraged activities in the home, for example, games, film nights and bingo, they had limited time to support people with activities in the community.

● Several people at the home required assistance to access the community for different reasons. Some people needed help to rebuild their confidence and skills while others needed physical assistance because they used wheelchairs when outdoors. However, staff had to prioritise people's health appointments, which left little time available to people for social support. The provider informed us they had applied for additional funding to provide 1-1 support to people who needed a wheelchair when they accessed the community.

● At the time of our inspection, five people had purchased their own mobile phones, which helped them stay in touch with their friends and relatives. However, during the pandemic lockdowns, people and their friends and relatives had struggled to keep in touch with each other. People had relied on the house phone or had occasional access to the deputy manager's mobile phone for video calls.

● People had access to a TV, a music system, games and books in the home. The provider arranged seasonal group events such as a Christmas meal at a local pub, and visits to a garden centre.

We recommend the provider support people to avoid social isolation and access the community based on their personal preferences and needs.

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

● The service involved people, their relatives and health and social care professionals to develop personalised care plans that reflected people's needs and preferences.
● The people we spoke with gave mixed views about the amount of choice and control they had in their day to day lives. People told us how COVID-19 had affected their lives negatively, for example, loss of activities, lack of community access, and reduced contact with friends and relatives.
● The relatives and friends we spoke with gave mostly positive views about the personalised care people received. They also commented on the impact of COVID-19 restrictions on their loved ones.
● Care records included people's preferences such as their preferred name, religion, and dietary preferences. The home celebrated people's birthdays. Staff provided special diets to those who needed or requested them, for example, some people did not eat pork for religious reasons.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The service took into account people's communication needs when planning care.

Improving care quality in response to complaints or concerns
● The service had a policy and process for managing complaints. Records showed that the service dealt with complaints and concerns appropriately and took the opportunity to learn lessons and make changes.
● None of the people we spoke with had any complaints about the service, but they knew how to complain and felt confident any issues would be addressed.

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service management and leadership.

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

- The provider and registered manager did not understand or meet all the relevant legal requirements and obligations associated with their registration. For example, they had failed to notify CQC of two incidents that took place in September 2021 and January 2022. On our request, the provider submitted the notifications soon after our inspection.

The provider had failed to submit statutory notifications where required to do so. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- At our last inspection, we recommended the provider implement a business improvement plan to evidence ongoing and sustained improvements. At this inspection, we found no such plan in place although we were advised of some changes that had been made, for example, the introduction of an annual All About Me review.
- The provider had not updated the residential capacity tracker. This is a digital data tool developed by the NHS that collects information on bed vacancies, staffing levels, and the impact of coronavirus, and provides essential planning information to several agencies.
- The provider had not followed safe recruitment practices or ensured safe staffing arrangements. The provider had not complied with the vaccination condition for staff requirement.
- The provider and registered manager did not fully understand their roles and responsibilities. The registered manager worked excessive hours mainly focused on care tasks. They showed disinclination for the registered manager role and told us they hoped the deputy manager would share the role in the future.
- During our inspection, our discussions with the provider and registered manager showed poor knowledge of CQC regulations, standards and requirements. They were unable to locate essential information sources such as CQC website, provider portal or GOV.UK websites.
- The registered manager described a reluctance to use information technology, and there was some evidence to indicate they had missed important information such as local authority bulletins and CQC updates as they rarely accessed their registered email address.
- The provider did not keep abreast of changes in practice, guidance, legislation, support and resources. They did not keep up-to-date and fully comply with government guidance related to COVID-19 in care homes.
- The provider had not accessed resources, support and funding available during the pandemic that would have benefited staff, people and their friends and relatives, for example, to purchase additional electronic

devices to help maintain contact with relatives; to help fund domestic staff cover.
● The provider did not link in with provider or local authority networks and forums that would have been useful for information sharing and keeping up to date with developments in the sector.
● The provider had some basic audit tools that helped them assess the safety and quality of the service and identify areas that needed attention. For example, they had an equipment checklist that helped ensure servicing of equipment and premises took place at the right time, but this had not included a person's bath chair. They had arranged for a pharmacy to complete audits on their medicines management systems and processes, but the last audit had taken place on 15 May 2019. The provider informed us that that the pharmacy had stopped doing site visits due to the pandemic.

The provider had inadequate management and leadership arrangements to ensure good governance and compliance with regulations and government guidance. This was a breach of regulation 17 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood its responsibility around the duty of candour and showed commitment to openness and honesty when something went wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider aimed to provide a safe and protective culture in a homely, familial environment. Staff encouraged people to maintain or improve their independent living skills. As COVID-19 restrictions eased, some people had started to 'get out and about' and one person had started college.
● The service had a protective culture that some people and their friends and relatives described as "strict at times." For example, some relatives we spoke with felt the home had been too strict about visiting and letting people go out. They also believed the home had delayed in 'opening up' when COVID-19 restrictions eased.
● Staff knew people well and we observed good interactions between people and staff. People described a family feel to the home. Staff described the registered manager as caring and approachable.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider did not keep people and their relatives updated on COVID-19 measures at the home and visiting arrangements. This led to confusion among people and their friends and relatives, and the following of restrictions that were no longer in force.
●The service engaged with people and their relatives regularly. They held residents' meeting every two-three months with the last meeting held in October 2021. They ran annual surveys for with people and relatives. We reviewed the results of the surveys ran in 2021, which showed positive feedback about the service.
● The service met the cultural needs of people. For example, staff supported people to practice their faith, access culturally appropriate activities, and eat appropriate food.

Working in partnership with others
● The service had close links with community health teams and GPs. The service worked well with other agencies to ensure people's healthcare needs were met.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit statutory notifications where required to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not followed safe recruitment practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient and robust staffing arrangements.

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 provider had not complied with national COVID-19 guidance that set out a range of infection prevention and control measures for care homes. The provider had not complied with the vaccination condition of employment for staff.

The enforcement action we took:

Issued Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management arrangements, systems and processes did not ensure good governance, monitoring and review of the service to ensure the delivery of safe and effective care. The provider did not maintain effective scrutiny and oversight of the service.

The enforcement action we took:

Issued Warning Notice