Community Care Solutions Limited

Aspen House

Inspection report

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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
Aspen House is a residential care home registered to provide personal care to people with Learning disabilities, autistic people and people with mental Health needs or Physical Disability. At the time of the inspection 8 people were living in the home. The service can support up to 10 people.

The home is separated into two wings, "The House" and "The Lodge". Both wings have a kitchen, dining area and a communal lounge. People's rooms have private en-suite facilities. There is an enclosed communal garden.

People's experience of using this service and what we found
Systems and processes in place had not been robust enough to maintain effective oversight of the safety and quality of the service. Where systems had identified issues, these were not addressed in a timely manner. The meant people had been at increased risk of harm.

There had not consistently been enough suitably trained and experienced staff deployed across shifts to ensure people's needs could be met. There was not always a positive culture in the home and staff had not been consistently satisfied with how the home was managed this had resulted in a high turnover of staff.

Risks to people were not consistently assessed and mitigated. We identified risks to people in the environment and from health-related issues.

Lessons had not consistently been learned when things had gone wrong, risk had not been reviewed and records updated following accidents and incidents.

Medicines were not consistently managed safely; we were not assured that people were receiving their medicines as prescribed. There had been several medication errors in the service, and we identified that staff medicine competency checks had not been appropriately completed.

People were not consistently protected from the risk of infection. Measures to monitor people for symptoms of COVID-19 were inconsistent and staff and people's test results were not recorded and monitored to protect people from the risk of infection. Staff did not follow government guidelines which required people returning to the service remain in isolation. This meant people had been exposed to increased risk of COVID-19.

The building did not represent a homely environment it was bare and uninviting with some furniture in a poor state of repair. The home was visibly unclean. Staff were responsible for cleaning but had no training in this area and did not have clear guidance to ensure good standard were achieved.

People were not consistently supported to have maximum choice and control of their lives and staff did not

consistently support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not consistently support this practice.

People had limited access to the support of their families for decision making and care planning and relatives did not consistently feel informed or involved in their relative's care. People were not supported with maintaining relationships and contact with their family as the provider was not following current government guidance on visiting in care homes.

People's privacy was not consistently maintained and there was evidence of people being frequently monitored throughout the night with no rationale for this practice.

The service was not operating within the principles of the MCA and some people were being deprived of their liberty without evidence of the legal authority to do so. Best interest decision was not consistently in place and where they were there was no evidence of involvement of advocates or family members.

The provider had failed to notify the commission of a significant event via a statutory notification.

People appeared comfortable with staff during the inspection and staff were patient an understanding with people. People were making daily choices around their care.

The provider had a complaints policy and procedure in place that was available in formats to meet people's communication needs. There was evidence of transparency with families when things had gone wrong.

People had enough to eat and drink and were supported to maintain a balanced diet. People had access to health care professionals as and when required and there was evidence of partnership working with other healthcare professionals.

New staff had been recruited safely.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Following the inspection, we received confirmation from the provider that DoLs (deprivation of liberty safeguards had been applied for). Following the inspection, we were assured that unnecessary monitoring had now stopped.

Right support:
• Model of care and setting maximises people's choice, control and independence
Right care:
• Care is person-centred and promotes people's dignity, privacy and human rights
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

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 9 January 2021).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, management of medicines and safeguarding. 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.

We have found evidence that the provider needs to make improvements.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aspen House on our website at www.cqc.org.uk.

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 their not being suitable numbers of staff with the right knowledge and experience deployed across the service. We also identified breaches in relation to safe care and treatment, managerial oversight of the safety and quality of the service and consent.

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

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.

Since the last inspection we recognised that the provider had failed to notify us of an incident that stopped the service from running safely and properly. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

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

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

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 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**

Aspen House

Detailed findings

Background to this inspection

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

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 by two inspectors. One inspector completed a site visit and made calls to staff; a second inspector made calls to relatives of people who used the service.

Service and service type
Aspen House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of

this information to plan our inspection.

During the inspection
We spoke with two people who used the service and six relatives about their experience of the care provided. We spoke with eight members of staff including two interim managers, a senior care worker and care and support workers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- The provider did not ensure risks to people from the environment were consistently mitigated. Window restrictors that had been identified at the last inspection as not meeting health and safety executive requirements had not been replaced. Heavy furniture such as tall shelving had not been secured to walls to prevent the risk of tipping and entrapment. One person's shelving unit and another person's bedroom drawers were in a poor state of repair.
- The provider did not ensure risks associated with fire were consistently mitigated. The lodge building did not have a working fire alarm and fire door system on the day of inspection. The registered manager had not implemented an interim risk assessment or safety measures to ensure risks were mitigated. Regular fire checks had not taken place in the previous month. Staff did not have access to the fire equipment and information needed in case of an emergency. Fire exit signage and emergency lighting was not consistently in place.
- Risk to people's health were not consistently mitigated. For example, staff did not have guidance or care plans to know the parameters to monitor a medical condition, or when to refer a person for medical care. Another person had been assessed by a speech and language therapist and required a specific type of cup for drinking. We observed this was not in use during the inspection and the person's care plan did not specify the cup to be used for staff guidance.
- People's risk assessments and care plans were not always updated regularly or when their needs changed. For example, a person had experienced a fall resulting in an injury and reduced mobility, their risk assessments had not been amended to reflect current risk. Another person's risk assessments and care plans had not been reviewed since 2019.

Using medicines safely

- Staff did not always receive the training and had their competencies checked to ensure they understood how to manage medicines safely. There had been a number of medicines errors.
- Medicines used to support with behaviour that challenged were not used appropriately. One person did not always receive their as required (PRN) medicine as prescribed. Records showed staff did not always follow plans of care by attempting all other de-escalation procedures before using PRN medicines. One staff member told us medicine was sometimes given without attempting de-escalation techniques. Staff did not record a rationale for why medicines were given, or how well they worked.
- Medicines were not consistently managed safely. Staff did not have access to protocols for people's PRN medicines. This meant people were at risk of not receiving their medicines when they needed them.
- People were at risk of ingestion or harm from flammable creams such as emollients as the provider did not ensure there were associated risk assessments.

Preventing and controlling infection

● The provider did not ensure staff were following current government guidelines to ensure people readmitted from hospital were placed in isolation. We observed a person readmitted into the service from hospital with no isolation plan and insufficient staffing to be able to assist the person to manage isolation as safely as possible. This put other people at a higher risk of contracting COVID-19.

● The registered manager failed to always collate and record staff COVID-19 results; they failed to ensure staff working in the home were COVID-19 negative and safe to work. This put people and staff at a higher risk of contracting COVID-19.

● Daily temperature checks were not consistently completed in line with the providers policy and procedure for monitoring people for symptoms of COVID-19.

● People were not consistently protected from the risk of infection. Cleaning records were not consistently completed, the home was visibly unclean with evidence of black mould in people's bathrooms and poor standards of cleanliness in people's rooms.

● Individualised deep clean schedules for people's rooms were not in place for staff guidance. Where deep clean records had been completed visual evidence did not support this had taken place.

● There was no evidence of mattress hygiene checks. We identified one person's mattress to be heavily soiled and with malodour of urine. This was replaced on the first day of inspection when highlighted by the inspector. A second mattress was found to be stained.

The provider failed to ensure risks had been assessed and actions to mitigate the risks were in place; to ensure medicines were managed safely or monitor and mitigate the risk of, and preventing, detecting and controlling the spread of, infections. This placed people at risk of harm as their safety was not effectively managed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was using PPE effectively and safely.

We have also signposted the provider to resources to develop their approach to infection control.

Staffing and recruitment

● The provider had not ensured there were consistently enough staff available to ensure people's needs were met. For example, during the inspection there were not enough staff deployed to ensure one person could be safely supported with an isolation period. There was also not enough staff to support another person who had required temporary increased support due to an injury.

● The registered manager and provider did not have an effective system and process in place to ensure shortfalls could be met. Records confirmed that suitable staff numbers to meet people's needs had been impacted by high levels of unplanned staff absence for several weeks. A staff member told us, "When they (the home) are fully staffed its ok, last time I was there they were really short (short of staff); people don't always get their one to one, manager (registered manager) said we are not allowed to have agency (temporary staff support)." This meant people were at increased risk of harm and not consistently receiving the support they needed or were funded for.

The provider failed to ensure there were sufficient numbers of staff be deployed in order to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider reassured the commission with the following statement. "Proactive

action has been taken by the project team, with a focus on roles, morale, sickness management and reviewing rotas to maximize support outcomes and commissioned hours." We have not assessed the effectiveness of this action at this inspection as this will need to be continued and embedded in practice.

● Staff were recruited safely. The provider had a system and process in place to ensure only suitable people were employed. Disclosure and Barring Service (DBS) checks were completed for all staff prior to them working with people. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes were in place to protect people from the risk of abuse. Staff had received training and could explain the signs of abuse. However, staff and the registered manager had not consistently recognised and raised concerns in a timely manner. Following an internal investigation, the provider identified some concerns that they reported retrospectively to the local authority and the Care Quality Commission.

● Staff had access to the providers confidential whistle blower service and there was evidence this had been used and responded to when required.

Learning lessons when things go wrong

● Accident and incident forms were available for staff completion and staff understood the importance of recording accidents and incidents. However, risk assessments had not been reviewed following accidents incidents to prevent reoccurrence.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- The provider and registered manager were not working within the principles of the MCA. People did not consistently have individual mental capacity assessments in place for each decision to be made. Best interest decisions were not consistently in place and where they were in place there was no evidence of involvement in decision making outside of the management team at Aspen House.
- Consent to photography and media forms containing complex information had been completed on behalf of individuals by the management team. These people had been assessed as lacking capacity to make complex decisions in all other areas with no evidence of a best interest decision
- A number of people's DoLs had expired and had not been reapplied for in a timely manner, this meant the provider did not have the legal authority required to deprive people of their liberty.

We found no evidence that people had been harmed. However, the provider failed to act in accordance with the Mental Capacity Act 2005. This placed people at risk of harm. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- The provider did not ensure staff consistently had the skills, knowledge and training to ensure the safety

and quality of the service. This meant people were at increased risk of harm. For example, there had been a number of medication errors reported to CQC prior to the inspection. We found that the registered manager had tasked a senior care worker with completing medication competency checks for all care staff. The senior carer was not suitably trained or qualified for this task. An interim manager agreed to check competencies of all staff to ensure people's safety following the inspection.

● Some staff training was overdue or had not taken place. One staff member told us, they had been expected to use a new piece of equipment for a person, they had not received training and did not feel confident in this task. Another staff member said they felt there was a lack of knowledge and understanding from staff around behaviours that challenge.

● Staff were responsible for cleaning the home including deep cleans of people's rooms. There was no evidence of guidance such as individualised cleaning schedules to support staff in this area. Staff had received some training in cleaning the environment via the providers COVID-19 Infection Prevention and Control training, but this had not been effective in achieving good standards.

● Despite the home being found visibly unclean on inspection with evidence of ingrained dirt and heavy dust some staff did not recognise this as an issue. One staff member said, "I think it's clean but its dated and needs some repairs." Another staff member said, "It (the home) needs doing up its not dirty."

We found no evidence that people had been harmed. However, the provider had failed to ensure staff were suitably, qualified competent, skilled and experienced. This placed people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People had an initial assessment prior to moving into the service. This was to ensure their needs could be met and risks mitigated prior to admission. Assessments included people's health conditions and behaviour support needs, religion, important relationships, culture, likes, dislikes and hobbies. This information had been initially used to plan peoples care and support.

● People currently living in the home had been there for a number of years, which meant there was no new information for us to review.

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

● People had enough to eat and drink and were actively involved in meal preparation as much as possible. People chose the food they wished to eat and had easy access to drinks and snacks as and when they wanted. Meal planners evidenced choice and a balanced diet.

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

● People had access to healthcare services as and when they needed it. There was evidence of contact with medical and care and support professionals where required and people had been supported with routine healthcare appointments.

● Where people were at risk of absconding, information had been recorded to support emergency services with locating the person in a timely manner.

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

● The building was adapted to meet people's needs. However, communal areas did not reflect an inviting homely environment. Walls appeared bare and clinical and furnishings were either absent or dated. Flooring and carpets were worn in some areas and required replacement. The provider had an improvement plan in place which would need to be continued in practice.

● People's rooms needed redecorating with some furniture requiring replacement due to poor condition

and risk of collapse. People had personalised their rooms with their own belongings and bedding.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- People had not always been well treated. Living conditions such as the cleanliness of the building was a concern and people were not consistently protected from the risk of harm.
- We observed people to be comfortable with staff during the inspection and staff were patient and understanding when supporting people with their individual needs. Staff were able to tell us individualised information about people's likes, dislikes and preferences. One staff member told us of their frustration of not being able to provide people with the one to one support they should have due to their not being enough staff deployed across shifts.
- The provider had an equality and diversity policy in place and people's religion and culture was recorded.

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

- People were making daily decision about their care. For example, they were choosing their meals, activities and clothes. One relative said, "[person] makes their own choices and how they like to live their life."
- Relatives did not consistently feel involved in decision making where people could not make some decisions for themselves. One relative said, "We used to have meetings about [person's] care but these are now held at a time I can't attend. This means I can't be involved in care plans and risk assessments."

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not always respected. There was evidence of over monitoring for some people without a clear rationale as to why this was in place. For example, half hour observations throughout the night for all people plus a separate two hourly check for all people. Staff told us they had been instructed to remove duvets that were over people's faces during checks and check for breathing staff told us this was disturbing people unnecessarily while they were comfortable and sleeping.
- We observed staff to knock on people's doors and announce their name prior to entering and ensure doors were closed when supporting people with personal care.
- Staff encouraged people to be as independent as possible, we observed people in the kitchen with minimal staff support encouraged to do things for themselves and one person talked to us about helping to clean their own room.

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.

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

- People had not been consistently supported to maintain relationships with their family. The provider had not implemented visiting arrangements in line with government guidelines for COVID-19. This had a negative impact on people and their families. One relative told us, "They [the home] are saying we can't visit yet. There are no arrangements for relative to come out yet, it would be nice if they let us." At the time of the inspection the guidance would have allowed this relative to visit regularly inside the home and for the person to go out of the home and visit their family member.
- People's independence outside of the home had been impacted by the pandemic. People had been supported to go out for walks and access the community when staffing numbers had permitted. At the time of inspection an interim management team were in place who were in the process of organising more activities. Following the inspection staff told us more outdoor activities were now taking place. This would need to be continued and embedded in practice.

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

- Care planning required review to ensure information reflected people's current needs and included input from relatives and advocates where required. One person's risk and needs assessment had not been reviewed since 2019 and made no reference to a religion or culture. This meant we were not assured staff had access to current information to ensure people had choice and control of their care as much as possible.

End of life care and support

- Staff had not consistently assessed and helped people to record their end of life care choices. End of life care plans required review to ensure they were in place where required, and fully completed. We found one person had a detailed end of life care plan in place which had been produced in pictorial format with parental involvement. Another end of life care plan had been started but not completed with no evidence of next of kin involvement.

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.

- Information had been made available in formats to meet people's individualised needs. For example,

records were available in pictorial and easy read where required.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure in place. There was one complaint recorded. This complaint had been actioned in line with the provider's policy.

● Pictorial and easy read complaints procedures were available. Neither people using the service or their relatives had made a complaint. One relative told us they had had no reason to complain and felt their relative was happy in the home.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There had not consistently been a positive culture within the home, staff were not consistently happy with the way the service was managed. One staff member said routines were frequently changed for people without rationale and told us for one person this had impacted by increasing their challenging behaviours. A relative said, "It takes [relative] a long time to learn to trust people, so it has been difficult for them to get to know staff when they have changed."
- Improvements were required to ensure an overall approach to person centred care which incorporated consent, family and advocate involvement and supporting relationships.

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

- The provider had failed to ensure systems and processes were robust enough to maintain effective oversight of the safety and quality of the service. For example, they failed to ensure all the required fire safety arrangements were in place. The meant people had been at increased risk of harm.
- The registered manager was required to complete a monthly workbook to provide operational overview to the provider which included details such as, accidents and incidents, fire risks, DoLS finance and medication. The workbook had not been completed since March 2021. There had been a delayed reaction of two months from the provider to address this with the registered manager. At the time of the inspection the provider had not had effective oversight of the service for three months as the outstanding workbooks and further workbooks had not been submitted.
- The registered manager had not maintained effective oversight of routine COVID-19 test results from staff and people who use the service to ensure any positive results could be quickly managed. The results had not been recorded since March 2021. Staff told us they were not routinely asked for their result. This meant people had been at increased risk of being supported by staff that failed to report a positive test.
- Provider audits had not consistently identified the concerns found during the inspection. Where concerns were identified via the providers auditing process these had not been actioned in a timely manner. For example, a provider audit completed in March 2021 had identified issues with consent and best interest decisions, risk assessing, and reviewing risk following accidents and incidents. The provider had failed to ensure these issues had been addressed at the time of the inspection.
- The provider's visitor risk assessment and business continuity plan had not been updated to ensure it was in line with current government guidance and the home was unnecessarily restricting people from spending time with loved ones in their home. There was also no guidance on readmissions from hospital. This meant

staff did not have access to current information to support people safely and support their personal relationships.
● The provider had failed to make improvements to the service since the last inspection where we highlighted issues that required improvement. For example, we identified that window restrictors were required to opening windows in line with the health and safety executive requirements. The providers internal audit in May 2021 identified a number of window restrictors were still required and recorded this required immediate action. This had not been completed at the time of the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider had not ensured staff had been kept informed or involved. Although there was evidence of regular staff meetings taking place, some staff had found these helpful and had felt listened to, other staff did not and told us they felt like they were instructions rather than meetings. Staff had not received regular supervision in line with the provider's policy and procedure.
● The provider failed to ensure people were involved in the decisions and running of the home. There was no evidence of home meetings or individual one to one meetings with people to encourage them to be more involved and share their thoughts and ideas.
● Relatives did not consistently feel involved with the service and the care of their family member. One relative told us, "I am not kept informed, they (staff) don't tell me anything. They take relative for hospital and dental appointments, but don't let me know the outcome, I have to ask." Another relative said, "I am not sure how I would hear if there was an incident or issues."

We found no evidence that people had been harmed. However, the provider failed to ensure systems and processes in place were robust enough to have effective oversight of the safety and quality for the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to notify CQC of an event that stopped the service from running safely and properly. This event related to the fire safety alarms.

We found no evidence that people had been harmed. However, this was a breach of Regulation 18(1) (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009

The provider recognised they needed to improve and at the time of the inspection, an internal investigation was underway into the service failings. An interim management team was supporting the service.

● There was evidence of partnership working with other professionals such as GPs, speech and language therapist and community disability teams.
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 had a good understanding of the duty of candour, there was evidence that families had been informed of accidents and incidents.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the mental capacity act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the requirement.

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 failed to ensure care and treatment was provided in a safe way for service users.

The enforcement action we took:

We will monitor the service by asking them to send us monthly reports.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that systems and processes operated effectively to ensure compliance with the requirements.

The enforcement action we took:

We will monitor the service by asking them to send us monthly reports.