North Corner Lewes Limited

North Corner 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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
North Corner Residential Care Home is a residential care home providing accommodation and personal care to up to a maximum of 16 people. The service provides support to older people who require support with some aspects of their daily living. At the time of our inspection there were 8 people using the service.

People's experience of using this service and what we found
The systems and processes followed by the provider failed to identify that care and treatment was unsafe. We identified several safeguarding incidents that had not been reported to the local authority or to the CQC. There was no oversight of safeguarding incidents by the provider.

Risks were not managed safely, or fully identified. Where risks were identified there was not always guidance to inform staff how to support people safely and consistently. Environmental risks were not managed safely, for example, there had been no recent fire risk assessment and there were no regular fire safety checks. The home was not clean and tidy and needed general maintenance throughout. Improvements were needed to ensure medicines were managed safely. Recruitment procedures were not robust and did not ensure staff were suitable to work at the home.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice.

A quality assurance system had previously been in place, but there had been no recent audits or oversight by the provider for a number of months. Records were not completed accurately and there was an apparent lack of commitment by the staff to improve and develop the home. Although the provider was aware of some of the concerns we identified, action had not been taken in a timely way to address these.

We observed staff engaging with people and supporting them with kindness. People approached staff freely. People told us the staff were kind and relatives spoke highly of the staff team.

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 01 September 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for North Corner Residential Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, safeguarding, fit and proper persons employed, need for consent, premises and equipment, good governance and notifications of other incidents.

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.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

North Corner 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 was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by 2 inspectors.

Service and service type
North Corner Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. North Corner Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. They were also the provider for the

service. They were supported in the day to day running of the home by a care manager.

Notice of inspection
This inspection was unannounced.

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

During the inspection
During the inspection we reviewed the records of the home. These included recruitment records, accidents and incidents and quality assurance audits. We looked at medicine administration, 4 care plans and risk assessments, along with other relevant documentation to support our findings. We spoke with everyone who lived at the home and got feedback from 2 of them and 3 visitors. We spoke with 6 staff members; this included the provider. We also received feedback from 3 health and social care professionals.

We observed people in areas throughout the home and could see the interaction between people and staff. We watched how people were being supported by staff in communal areas, this included the lunchtime meals.

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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff did not always protect people from the risk of abuse. Incidents had been reported by staff, however these had not been identified as abuse. Referrals had not been made to the relevant safeguarding teams or to CQC. This meant people were not always protected from the risk of ongoing harm or abuse. There was a safeguarding policy which provided clear guidance, but this had not been followed.
● Staff completed incident forms when they identified an accident or incident or when someone had had a fall. However, these forms were not accurately completed. One stated the incident to be 'violence and aggression'. There was no information to describe what happened or what actions were taken at the time to keep people safe. There was no information to show this had been reviewed by the management team, or to show what actions had been taken to ensure measures were put in place to prevent a reoccurrence.

People were at risk of harm and abuse because systems and processes that were in place to protect them had not been operated effectively. This is a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us that if they were concerned that abuse was taking place, they would report this to the management team who would take action. Staff were aware they could report concerns to the local authority safeguarding team or the police. However, they were confident management would take the appropriate action.

Following the inspection the provider made the appropriate referrals to the local authority safeguarding team and sent us evidence to show this had been done.

Assessing risk, safety monitoring and management
● Not all risks were fully identified, where they were identified there was limited guidance to inform staff how to support people safely. Risk assessments identified two people at risk of developing pressure damage. However, there was no information about how to prevent this. Another person had been identified at risk of choking, but there was no guidance on how to support them safely.
● Some people had risks associated with their health needs such as diabetes. There was no information about how to manage diabetes or the potential effects this could have, for example on people's feet and eyes. There was no information about how to maintain good foot hygiene or regular eye checks.
● Risks to people's personal hygiene were not well managed. Two people's care plans stated they needed support with personal and oral care and continence support. The daily notes stated these people were

already up and dressed when staff came on shift. There was no information to show what support had been given to maintain people's continence needs. Staff told us some people declined personal care. However, there was no information to guide staff about how to ensure people received appropriate support. Minutes from a recent staff meeting stated the provider had reminded staff about the importance of maintaining people's personal hygiene, as some people had been found to be unkempt.

● Some people displayed episodes of anxiety, distress or anger. There was no guidance for staff about how to support people during these upsetting times. There was no information to identify what may trigger these episodes, how to reassure or de-escalate situations. Whilst we saw staff attending to people with kindness the lack of guidance meant people were at risk of receiving care that was not consistent and this could prolong or exacerbate their anxiety and distress.

● Environmental risks had not been safely managed. Recent legionella testing had taken place. However, there was no legionella risk assessment for ongoing monitoring. Water temperature checks, run through of standing water and shower head cleaning was not taking place. There was no risk assessment or schedule to determine what checks or frequency these were needed. The provider told us water temperature checks of bath water took place before people had a bath. Stairgates were in place at the bottom of staircases. There were no risk assessments to determine if these were the correct height for people or if they could pose a trip hazard if people attempted to climb over.

● There had been no recent fire risk assessment. Regular fire checks such as fire alarms, emergency lighting and door-guards were not checked throughout the year. Personal emergency evacuation procedures were not up to date and did not include details of people recently admitted to the home.

● Some windows on the first and second floors opened wide. These were accessible to people, some of whom were living with dementia, and left them at risk of falling from height. We saw cleaning products which were classed as Control of Substances Hazardous to Health (CoSHH) had not been stored securely. We found a cupboard where products had been stored was locked, but the key was in the lock. We found another CoSHH product had been left in a person's room.

● Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) checks to ensure lifting equipment in baths was safe had been completed in the past year. However, these should be completed every 6 months. The provider told us the stair lifts at the home were no longer in use.

The provider failed to identify, assess and mitigate risks to people. These issues are a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we sought reassurances from the provider that window and CoSHH safety had been reviewed and improved. The provider confirmed that action had been taken and these areas were now safe.

Using medicines safely

● Medicines systems and processes were not safe.

● Medicines were not stored safely. We found out of date medicines and medicines which had not been dated on opening to ensure they were used within the stated timescales. This included prescription creams in people's bedrooms.

● We found medicines were stored in a variety of places around the home. Some people had excess quantities of creams and medicines. We found prescription medicines which were out of date, and medicines for people who no longer lived at the service.

● One medicines administration record (MAR) indicated that the person was receiving their medicines covertly in a milkshake. No documentation could be found to determine whether this decision had been made in accordance with any other health professionals, or steps had been taken to confirm that this was a safe and effective way to give this medicine safely.

● Controlled medicines (CD's) had not been accurately documented or reviewed. CD medicines must be stored securely and the quantity recorded within a controlled medicines book. We found 2 prescriptions for Lorazepam in the CD cupboard. One went out of date in September 2022, the other did not contain the correct number of tablets according to the CD book.
● We found gaps and errors on the MAR. Gaps had not been explored and running totals for medicines remaining did not correlate. Administration of prescribed creams was not accurately recorded.
● As required or 'PRN' medicines did not all have guidance in place to inform staff how and when they should be given and actions following administration were not recorded. For example, whether the medication had been effective.
● Temperatures had not been recorded to ensure medicines had been kept at the appropriate temperature. No fridge temperatures could be found.
● There were no medicines audits or checks completed to identify issues or errors. Staff competencies for medicine administration had not been assessed.
● Medicines policies did not include covert or homely medicines guidance. The provider had not been providing medicines safely, this put people at risk of harm from not receiving their medicines safely.

The provider failed to ensure people were supported to receive their medicines safely. These issues are a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. The home was not clean and tidy throughout. Attention was needed to ensure all areas of the home were cleaned regularly and appropriately. For example, one bath was unclean. There was a bath seat which was also unclean both on the seat and underneath. There was a non-slip bathmat which was for use in the bath, but this was on the floor. This had split in half which also posed a risk as a trip hazard. On the floor of the bathroom was a wash bowl and plastic jug. The provider told us hese were used for washing people's feet if they did not want a bath. However, these were stained and did not appear to have been cleaned appropriately.
● There were toiletries in bathrooms. These were un-named. The provider told us these were 'communal toiletries' that anyone could use as not everybody had their own toiletries . This put people at risk of harm from cross infection.
● People's bedrooms and personal items were not always clean. In a number of bedrooms there were thick cobwebs on the window. In other rooms, ornaments and cupboards were dusty. These did not appear to have been cleaned for some time.
● Within the laundry there were separate washing machines for soiled and unsoiled linen. Some clothing, which could not be tumble dried, was dried in a boiler room which was warm. However, there were floor mops, in buckets with water, underneath the clothes.
● There were cleaning schedules in place. These had recently been updated and did not reflect all the areas previously identified as requiring cleaning. Recent records had not been completed to show what cleaning had taken place. Audits had not been completed to identify areas that needed further cleaning.

These issues meant people were not protected from the risk of cross infection. The provider failed to assess, prevent, detect and control the spread of infection. These issues are a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● Family and friends were free to visit the home whenever they wished.

Staffing and recruitment

● Recruitment processes were not safe. The provider had not ensured that appropriate checks had been completed before staff started work at the service. Recruitment files did not include fully completed application forms and gaps in employment history had not been explored.

● Appropriate references had not been sought. We found that one reference had been written by a current staff member at North Corner for a person applying to work at this service. The reference related to a prior employment some years ago, which had not been included on the person's application form. The dates given for this employment were not accurate and the place of employment had closed prior to the dates of employment given. These dates actually related to a period of time when the new staff member was working elsewhere. A professional reference had not been sought from the most recent employer and no rationale had been given to explain why this was not in place.

● Staff files did not all contain photographic identification for new staff.

Appropriate checks had not been made to ensure staff employed were suitable to work at the home. These issues are a breach of Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) checks were in place. These provide information including details about convictions and cautions held on the Police National Computer.

● The provider and care manager there were enough staff working each shift to support people. There were 4 staff working in the morning. This included the housekeeper and cook. The care manager was supporting people in addition to their managerial work. In the afternoon there were 2 care staff working, they were also responsible for preparing and serving the tea-time meal.

● In light of the concerns identified throughout this report this is an area that needs to be improved. The provider needs to regularly review staffing levels to ensure there are enough staff to meet the needs of people, and to improve and ensure a high quality of the service is provided.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not always following the principles of the Mental Capacity Act. Mental capacity assessments had not been completed for some people who were deemed to lack capacity. Mental capacity assessments and best interest decisions were not in place where there were restrictions on people, for example sensor mats and covert medicines being given.
- One person had an audio monitor in their bedroom. This meant staff could listen to them when they were in their bedroom. We were told this was to help monitor the person's safety. There was no mental capacity assessment or best interest meeting to consider if less restrictive measures could be used. There was no guidance for staff about how to manage this to help ensure the person's dignity was maintained.
- Consent forms were in place, for example in relation to care plans and photographs. Some of these had been signed by relatives who did not have the legal authority to consent on the persons behalf. One person's care documentation stated a relative had legal authority to sign on the person's behalf. However, further discussions with staff identified this was not correct and the relative did not have this legal authority.
- There was no oversight of DoLS applications and authorisations. Staff were not able to tell us who had a DoLS in place. We identified one person had conditions attached to their DoLS. Staff did not appear aware

of this and there was no information to show if this condition was being complied with.

People did not have their care and support needs delivered in line with MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Improvements were needed to some aspects of the design and decoration of the service
● Attention to detail in maintenance, decoration and cleanliness were required. There were broken wardrobes and chests of drawers in people's bedrooms. Some walls were in need of general repair and redecoration where damage had previously occurred. Some toilets appeared stained. Although this did not impact on people's safety it was unpleasant to look at.
● At the time of the inspection the boiler was not working. This was being addressed. People had portable heaters in their rooms, but these had not been risk assessed to determine if they were safe and how to manage these to ensure people remained warm and could maintain their personal hygiene .
● Areas of the home were cluttered and untidy. Although this did not impact on the safety of people it was not conducive to a homely living environment.

These issues were a breach of Regulation 15 Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Electrical service certificates were in place and the provider told us they would receive a gas safety certificate once the work had completed which they would share with CQC. The provider sent us risk assessments for the portable heaters after the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they moved into the home. Care plans were developed and reviewed. Recognised tools were used to assess people's level of risk of skin damage, malnutrition and oral health needs. However, we found that care plans did not contain information needed to support people. This is discussed in the safe and well-led section of the report.

Staff support: induction, training, skills and experience
● Improvements were needed to ensure training and supervision was relevant to the needs of people and staff. There was a training program and staff received face to face training. One staff member told us this was useful and they were able to learn new things. However, staff did not receive training relevant to the needs of all the people at the home, for example around diabetes. We were told staff who gave medicines had been assessed as competent, but there were no records of this.
● We were told the trainer used question and answer scenarios to determine staff understanding. Staff also received practical moving and handling training. There was no information to demonstrate that staff knowledge and skills were regularly assessed.
● There had been no recent supervisions to identify areas where staff needed to improve or develop their practice. The provider told us after the inspection these had commenced.
● Staff new to the home completed an induction period, this included shadowing more experienced staff until they were assessed as confident and competent to work unsupervised.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink a variety of food and drink throughout the day. One person told us they enjoyed the food. They said, "It's lovely." We saw people asking for tea and coffee throughout the day and this was provided. One person asked for a slice of chocolate cake during the morning and this was

given.

● We saw staff supporting people at mealtimes. This was provided appropriately and staff prompted and encouraged people to eat. Staff understood people's dietary needs and choices.

● Nutritional care plans and risk assessments were in place. People were weighed regularly to help staff identify any additional nutritional risks. One person had been identified as not eating and drinking and a referral had been made to the GP service.

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

● People were referred to health care professionals and services when needed and when their health needs changed. A healthcare professional from the GP surgery contacted the home weekly to discuss the needs of people. Staff had regular contact with district nursing teams to help support people where needed, for example, wound care.

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 leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was a lack of oversight in respect to the quality of care provided. The provider did not have systems in place to identify and address areas of concern identified in the safe and effective sections of this report. Where areas for improvement were identified action had not been taken to address these in a timely way. This included the safety, general cleanliness and maintenance of the home. Audits were previously in place, but these had not been completed since June 2022.
- The provider was supported by a care manager who was implementing a number of changes. However, there was a lack of organisation. For example, some documents related to the safe running of the home had been misplaced and were not available during the inspection. There was no overview of which people had DoLS in place, or who was for resuscitation in case of cardiac arrest.
- Care plans, mental capacity assessment and risk assessments lacked information. They did not reflect the care and support people required. Where risks were identified there was no guidance on how to manage these. The lack of information put people at risk of receiving inconsistent care and support. This lack of information had not been identified.
- There was no oversight of medicines by the provider or care manager to identify the shortfalls we found. There was no oversight of accidents, incidents and falls. There was no analysis or review to identify themes and trends. Therefore, actions had not been taken to prevent a reoccurrence.
- Policies were not always followed and did not always contain all the information staff may need. The safeguarding policy had not been followed. The infection prevention and control policy did not include any specific information about how to currently manage Covid19. The medicine policy did not include covert or homely medicines guidance.
- Measures were not in place to learn from incidents and prevent reoccurrences. Incident and accident forms were not accurately completed. They did not include details of the incident or actions taken. One incident form stated 1 person had shouted at another. The 2nd person then pinched the 1st person. However, there was no information about actions taken. Care plans and risk assessments had not been updated to ensure all staff were aware.
- A further incident form described an incident and stated there was no pattern or triggers to the incidents. However, there was no analysis of previous incidents to determine what triggers there may be and how to support people to prevent reoccurrences. Referrals to health and social care professionals had not been made.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

● After the inspection the provider responded to the concerns identified. This included the safety and maintenance of the home and commenced audits. They also gained support from an external consultant.
● Throughout, and following the inspection, the provider showed a commitment to making improvements at the home. They responded to the concerns identified. This included the safety and maintenance of the home and commenced audits. They also gained support from an external consultant to help develop the service and staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Improvements were needed to the culture of the service. Whilst staff were individually caring and were seen to engage appropriately and kindly with people there was a lack of teamwork to help drive and improve the home. This included the lack of quality in relation to people's records and the tidiness and cleanliness of the home. Staff had not received recent supervision to identify areas for development.
● The views of people, relatives, staff or visiting health and social care professionals had not been sought. There had not been any quality assurance surveys to gain views on the home. We were told that a recent residents meeting had taken place to discuss activities and menu planning. This had not been recorded.
● A recent staff meeting had been held, staff had been reminded about the importance of supporting people with their personal care. The minutes also stated that a key worker system was due to be introduced. This meant people would have a designated staff member who would be a central point of contact, for example, to ensure they had enough toiletries or appropriate clothing. Although provider had identified this it had not yet been implemented.

The provider had failed to establish and operate effective governance systems to assess, monitor and mitigate the risks to people's health, safety and welfare. Some records were not in place, accurate or complete. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

● People spoke well of the home. One person told us, "Staff do their best, if you need something they will sort it for you." Relatives told us they were kept informed about their loved ones. They said they could contact the home at any time and would always be informed of any changes. One relative told us, staff were "loving and caring," they also said they were impressed at how their loved one had been supported to settle into the home.

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
● Relevant statutory notifications had not been sent to the CQC when required. After the inspection notifications were submitted but these did not include all the information that was required. We contacted the provider and care manager to obtain all the relevant information.

The failure to submit notifications is a breach of Regulation 18 notification of other incidents Care Quality Commission (Registration) Regulations 2009.

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 notify the Commission of safeguarding incidents and accidents involving injuries to service users. 18(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not following the principles of the Mental capacity Act 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were protected from abuse 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises and equipment were well maintained. 15(1)(a)(e)

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 ensured proper recruitment procedures were established and followed. 19(1)(2)(3)

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 ensured the safe care and treatment of people. 12(a)(b)(c)(d)(e)(g)(h)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assured appropriate systems and processes were in place to fully assess, monitor and improve the quality and safety of the service provided. The provider had not maintained accurate and complete records for each service user. 17(1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

Warning notice