Kodali Enterprise Limited

Woodside Care Home

Inspection report

Lincoln Road
Skegness
Lincolnshire
PE25 2EA

Tel: 01754768109
Website: www.woodside-carehome.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Woodside Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to 42 people, including older people and people living with dementia. There were 25 living in the home on the first day of our inspection.

We carried out a comprehensive inspection of the home in May 2015. At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HCSA). This was because there were shortfalls in the monitoring of service delivery and people's legal rights under the Mental Capacity Act 2005 were not fully protected. We rated the service as Requires Improvement.

In November 2015 we carried out a focused, follow up inspection to check the registered provider had taken the actions necessary to address the breaches of regulations. We found both breaches had been addressed although the rating of the service remained as Requires Improvement.

In July 2016 we undertook a further comprehensive inspection. We found the progress noted at our November 2015 inspection had not been sustained. We found three breaches of the HSCA. This was because the registered provider was again failing to monitor the quality of service delivery effectively. We also identified concerns about the state of repair of the premises and shortfalls in infection prevention and control practice. The rating of the service remained as Requires Improvement.

In January 2017 we carried out a focused, follow up inspection to check the registered provider had taken the actions necessary to address the breaches of regulations. We found two of the three breaches had been addressed although the registered provider had still not taken sufficient action to address the shortfalls in organisational governance and improve the monitoring of service quality. The rating of the service remained as Requires Improvement.

In September 2017 we carried out a further comprehensive inspection. Again, we found the registered provider had not sustained the progress noted at our January 2017 inspection. We found two breaches of regulations. This was because the provider was still not monitoring the quality of service delivery effectively. We also found the provider was failing to assess and manage potential risks to people's health and safety and there were shortfalls in the management of people's medicines. The rating of the service remained as Requires Improvement. Following this inspection the registered provider wrote to us and advised us that action to address the two breaches of regulations would be taken by 31 March 2018.

On 13 and 19 June 2018 we carried out this further focused follow up inspection to check if the registered provider had taken the actions necessary to address the two breaches of regulations found at our September 2017 inspection. This report only covers our findings in relation to these issues. Our inspection was also scheduled in response to information shared with us by the local authority safeguarding and

contracting teams. They had visited the home in late May and early June 2018 to investigate concerns primarily relating to the cleanliness of the home and infection control practices. Their investigation was ongoing at the time of our inspection.

At this inspection we were extremely disappointed to find that the quality of service, far from improving, had deteriorated and people were not receiving the safe, well-led service they were entitled to expect. The provider was in continuing breach of both breaches of regulations identified at our previous inspection. This was because of the provider's ongoing failure to properly assess and mitigate risks to people's safety and a persistent failure over several years to effectively assess, monitor and improve the quality of the service. We found one further breach of the HCSA. This was because of the provider's failure to employ sufficient housekeeping and care staff to meet people's needs and to ensure compliance with regulatory requirements. We also found two breaches of the Care Quality Commission (Registration) Regulations 2009. This was because of the provider's failure to notify CQC of a serious injury to a service user; deaths of service users and allegations of abuse of service users.

Reflecting the findings of our inspection, we rated the home as 'Inadequate' and placed it in 'Special Measures'.

We also took enforcement action against the registered provider and the registered manager. Details of the action taken can be found at the end of the full version of this report.

In other areas further improvement was also required. We found little evidence that the provider had a systematic approach to responding to significant incidents to reduce the risk of something similar happening in the future. Staff at all levels expressed their concerns at aspects of the registered provider's financial management of the home. There were very few links between the home and the local community.

More positively, since our last inspection we found the provider had taken action to improve the safety of staff recruitment. Staff told us they worked well together in a mutually supportive way. Staff knew how to recognise and report any concerns under local authority safeguarding procedures.

The home had a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider') they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had an open, accessible style and was liked by his team. Throughout our inspection the registered manager maintained an open and non-defensive approach, despite the many issues of concern we identified. He also talked about his relationship with the provider with admirable candour.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were numerous health and safety concerns with the premises and equipment.

Systems to prevent and control infection were ineffective and unsafe.

Some people's medicines were not managed safely.

There were insufficient sufficient housekeeping and care staff to meet people's needs and to ensure compliance with regulatory requirements.

There were shortfalls in the provider's risk assessment and care planning systems.

Care practice was not consistently safe.

There was little evidence of organisational learning from significant incidents.

Staff were aware of adult safeguarding procedures

Staff recruitment was safe.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to monitor and audit service provision remained ineffective.

The provider had failed to take effective action to address areas for improvement highlighted at previous inspections.

The provider had failed to notify CQC of serious injuries sustained by people living in the home and other notifiable issues.

There were few links between the home and the local

community.

Staff at all levels expressed their concerns at aspects of the registered provider's financial management of the home.

The registered manager was well-liked by his team and displayed an admirably open and candid approach.

Staff enjoyed their job and worked together in a mutually supportive way.

Woodside Care Home

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of Woodside Care Home on 13 and 19 June 2018. This was to check that the improvements to meet legal requirements planned by the provider after our comprehensive inspection of September 2017 had been made.

In preparation for our visit we reviewed information that we held about the home such as notifications (events which happened in the home that the provider is required to tell us about) and the reports of our previous inspections of the home. We also took account of information shared with us by the local authority safeguarding and contracting teams from their ongoing investigation of concerns relating to the cleanliness of the home and infection control practices.

We inspected the home against two of the five questions we ask about services: 'Is the service safe?' and 'Is the service well-led'. On the first day of our inspection our team consisted of an inspector and a specialist advisor whose specialism is nursing. On the second day our inspector returned alone to complete the inspection.

During our inspection we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with the registered manager, the deputy manager and two members of the care staff team.

We looked at a range of documents and written records including five people's care files, two staff recruitment records and cleaning schedules. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Inadequate

Is the service safe?

Our findings

At our last inspection of the home in September 2017 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of the provider's failure to assess and manage potential risks to people's health and safety and shortfalls in the management of people's medicines. Following this inspection the provider wrote to us and advised us that action to address this breach of regulations would be implemented by 31 March 2018.

However, at this inspection we found the provider had failed to take sufficient action to address the breach of Regulation 12 and there were still multiple areas in which people's safety and welfare were not properly protected.

We identified numerous concerns with the safety of the premises and equipment. In one person's bedroom we found the heavy wooden radiator cover was not secured to the wall creating the risk that someone would be injured if it fell forward. Similarly, in two bedrooms we found the headboard was not attached to the bed, increasing the risk of injury to anyone using the bed. The lock on the staff room door had been removed which meant it could be easily accessed by the people in the home, many of whom were living with dementia. We found several health and safety hazards in the unlocked staff room including a broken fluorescent tube lying amidst sharp shards of glass; two bottles of boiler maintenance chemicals marked 'not to be taken internally' and a large bottle of disinfectant marked 'do not swallow'. When we showed these hazards to the registered manager he said, "It's terrible." He went on to explain that the staff room lock had been taken off to replace a broken toilet lock elsewhere in the home and that he was unaware that it had not been replaced. The third floor of the home was not used by the people living in the home but the stair gate which restricted their access to the steep stairs which led to this area was open. Commenting on this lapse, the registered manager told us, "I expect the stair gate to be closed to minimise [the risk of] falls." Additionally, the former staff flat at the top of the stairs had no lock, creating the risk that people could have entered it via the open stair gate. On the floor of the flat we found a broken mirror with sharp shards of glass.

We found two fire doors which were clearly marked 'Keep Shut' but which were blocked open with chairs. When we drew the registered manager's attention to this potential risk, he commented, "I would not expect that. I don't know who has done that." One of the handles on the bath hoist in the main bathroom of the home was loose, creating the risk it could fall out and injure someone using the hoist. Commenting on the faulty hoist, the registered manager told us, "It's been repaired several times. It needs doing again." The linoleum on the corridor near the dining room had started to rise from the floor creating a trip hazard to anyone walking over it.

Following concerns raised during the recent visits by the local authority safeguarding and contracting monitoring teams, on the first day of our inspection the deputy manager told us that the first aid kits in the home had "all [been] checked … the other day". However, when we opened the first aid kit in the kitchen we found dressings with an expiry date of June 2017 and latex gloves with what appeared to be blood stains. Acknowledging this shortfall, the deputy manager said, "[The first aid kits] have not been checked very well."

We also identified numerous concerns with the cleanliness of the home which presented an increased risk of cross-contamination and infection. We found cobwebs in many parts of the home some with their spiders still in situ. In one person's bedroom we found a dead woodlouse trapped in a cobweb in their ensuite bathroom. In another person's bedroom a long cobweb was hanging down from the ceiling, directly above their pillow. There was a strong smell of urine in two bedrooms and several ensuite or communal toilets had encrusted urine under the seat, indicating they had not been cleaned thoroughly for some time. Examining one of these toilets in the company of our inspector, the registered manager acknowledged, "It's not been cleaned effectively." Some of the easy chairs in the communal lounges also smelled strongly of urine. In one of the communal toilets we found what appeared to be encrusted faeces in the hand basin. In one person's ensuite toilet the vinyl covering on the toilet seat had started to peel off and the woodchip underneath was heavily stained.

Throughout the home, in communal and ensuite toilets, we found exposed pipework and cracked or poorly fitted floor coverings which acted as magnets for dust and dirt, creating an additional cross-contamination risk. On the morning of the first day of our inspection, we watched one member of staff pick up a flannel from someone's ensuite floor and put it on their hand basin where it was likely to have been used later in the day. On the morning of the first day of our inspection we saw a member of staff was about to serve tea to people in heavily stained tea cups. When we drew this to the attention of the registered manager he asked the member of staff to take all of the tea cups back to the kitchen and ensure they were washed effectively. However, later that day we saw another member of staff serving tea to people using stained cups, one of which was cracked. Some of the tiles in the kitchen were covered in thick, ingrained grease and the handle of the cutlery drawer in the food serving area in the dining room was also thick with grease. When we discussed these issues with the registered manager he told us, "I'm not happy with the cleanliness of the home. The home [was] clean until we had respite people weeing everywhere." The registered manager went on to say, "Last week there was more of an odour … [but] … we have been working on it since the [local authority] inspection last week." However, in the light of our findings, there was clearly much further work to be done to ensure effective systems of infection prevention and control.

We also identified concerns about the provider's approach to assessing and managing possible risks to people's safety and well-being. Describing the admission process, the registered manager told us, "I try to get [the person's care plan] done straightaway [following admission]." However, when we reviewed people's care records we found that one person who had moved into the home on 19 May 2018 did not have a care plan to provide staff with guidance on how to meet their individual needs and preferences. This was despite staff having assessed the person as being at risk of choking. When we raised this issue with the registered manager he said, "I don't understand why that happened." Similarly, another person had returned to the home from hospital the day before the first day of our inspection. During this person's stay in hospital their care needs had changed significantly in a number of areas including mobility and nutrition. Although the registered manager told us he had verbally briefed the care and catering teams about these significant changes, staff had not reviewed or updated the risk assessments that had been in place before the person went into hospital. Commenting candidly on the process of preparing individual risk assessments for people living in the home, the registered manager told us, "They are not always done straightaway [on admission or re-admission] if I am honest." In a further worrying comment, one member of the care team told us, "I don't have time to read the care plans."

Reflecting these shortfalls in the risk assessment and care planning processes, throughout our inspection we observed instances where staff practice did not take proper account of potential risks to people's safety and welfare. For example, on the morning of the first day of our inspection we saw one member of staff pushing someone through the home in a wheelchair. There were no footplates fitted to the wheelchair and the

person's feet were hovering just above the floor. Additionally, the seatbelt fitted to the wheelchair was not in use. When we discussed this incident with the deputy manager she told us she would have expected both the footplates and the seat belt to have been used. However, later in the day we saw another person being pushed through the home without their wheelchair seat belt being used. Similarly, on the morning of the first day of our inspection we saw one person walking round the home with only one shoe on. When we drew the registered manager's attention to this issue he told us that the lack of a shoe would "increase [the person's] risk of falling". He asked a member of staff to "sort it out" but throughout the rest of the day we saw the person still walking around the home with only one shoe.

When we reviewed the record of staff training maintained by the registered manager, we found significant gaps in the provision of training courses which the provider had deemed to be mandatory to help protect people from harm. For example, for five members of the care staff team there was no record of them having had moving and handling training. Similarly, there was no record of 10 staff having had infection control training including one member of the housekeeping team; for nine members of the care team there was no record of any health and safety training and for 11 there was no record of any safe food handling training. When we talked with the registered about the gaps in the provision of mandatory training and the increased risk of unsafe practice this created, he told us, "There [has been] no programme of annual refresher [training]. [The] budget is an issue."

We reviewed the arrangements for the supply, storage and administration of people's medicines and found that this was still not consistently safe. For example, on the first day of our inspection we watched a senior member of staff conducting the lunchtime medicine round. On three occasions the staff member left the medicines trolley out of their line of sight with the door unlocked and key still in the lock, increasing the risk someone without authorisation could access the medicines stored in the trolley. When we raised this concern with the registered manager he told us, "[Name]'s practice should be spot on. [Name] trains the others." As described earlier in this report, the staff room was unlocked and could be accessed easily by the people living in the home, many of whom were living with dementia. In addition to broken glass and hazardous chemicals we found in the staff room, we also found a partially used bottle of one person's prescription medicine. This should have been kept securely in the medicines store room or trolley rather than lying loose in the staff room.

We were also concerned to find that a tub of thickening powder prescribed for the use of one person identified as being at risk of choking was kept in their bedroom rather than in the medicines store room or trolley. Acknowledging the risk this unsafe storage practice presented to the people living in the home, the registered manager told us, "It is likely that someone [living in the home] would go in [to the person's bedroom]. It [should have been] kept somewhere else." This was despite the fact that the registered manager told us he aware of an NHS patient safety alert issued in February 2015 in response to the death of a care home resident following the accidental ingestion of a thickening powder that had been left within their reach. This alert instructed 'all providers of NHS funded care where thickening agents are prescribed, dispensed or administered' to ensure arrangements were in place to ensure appropriate storage of thickening powder by 19 March 2015.

The provider's ongoing failure to properly assess and mitigate risks to people's safety was a continuing breach of Regulation 12(2)(a),(b),(c),(d),(e),(g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we identified concerns about staffing levels in the home. Firstly, in relation to the housekeeping team, staff told us there insufficient staff employed in the housekeeping team and that this contributed to the poor cleaning and infection prevention practices described above. For example,

commenting on the cleanliness of the home one member of the care team told us, "There are not enough cleaners. Quite often there is just one … to do 42 bedrooms and the lounges and the laundry. It's just too much for one person." Another member of the care team said, "I think the home smells. Some days we only have one cleaner in. It's too much for one person … to get to all the rooms and do the laundry. Sometimes they don't enough time to do it all [and] you walk into a room [and it] can smell." The registered manager confirmed that there were two members of staff employed in the housekeeping team who, between them, worked a total of 70 hours a week. However, each team member had two days off each week which meant that on four days a week there was only one member of the team in the home. The registered manager told us that he intended to recruit an additional member of staff to the housekeeping team to take a lead on laundry, although the recruitment for this new post had not started. As a temporary measure, the registered manager told us he had arranged for a member of the care staff to work in the laundry. However, in the light of the significant concerns we identified with the cleanliness of the home, it was clear that further action was required to ensure the effective deployment of staff in the housekeeping team to meet the provider's regulatory responsibilities in this area.

Staff also shared their concerns about the safety of staffing levels in the care staff team, particularly during the period from 2pm to 9pm when there were only three members of staff deployed on shift. For example, one member of the care team said, "We need an extra person in the afternoon. If the senior is doing medicines and [the other two staff members on shift] have to do a double up (providing personal care to someone who needs the support of two members of staff) there is no one on the floor [to supervise the other 24 people living in the home]." Outlining further concerns about the negative impact on people's welfare of the current staffing levels in the home, another staff member told us, "We aim [to offer] each person one [bath or shower] a week. It's not enough. I wouldn't like one bath or shower a week. Why should they? We'd like to offer more [but there is not enough] time and staff to get them all in."

When we discussed these concerns with the registered manager he told us that the provider had recently increased staffing levels on the 7am to 2pm shift. Confirming that this had only been done in response to the recent local authority safeguarding investigation, he said, "[Before they came] we [only] had three care staff on from 10am to 2pm. That had been the position for a while. In February it got crazy with loads of respite residents coming and going. We had insufficient staffing and, with respite, we didn't know the residents. [But] we didn't get any more staff [at that time]. After the safeguarding visit [my deputy and I] sat [the owner] down and changed the rota. We increased to four from 10am to 2pm." However, the registered manager also confirmed that no change had been made to the 2pm to 9pm shift to address the risks to people's safety and well-being described above. He acknowledged that "three [staff on that shift] is not sufficient" and that he planned to recruit additional staff to enable four to be deployed on this shift "as soon as possible". However, when asked by our inspector why the provider was not using agency staff as a temporary measure to address the insufficiency of staff in the 2pm to 9pm period that had been identified, the registered manager said, "I think [the owner] would have a heart attack [if I employed agency staff]. We have never had agency. He thinks they are too expensive."

The provider's failure to employ sufficient housekeeping and care staff to meet people's needs and to ensure compliance with regulatory requirements was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the registered manager told us, "I always try to learn if I feel we could have done things better", we found little evidence that the provider had a systematic approach to responding to significant incidents to reduce the risk of something similar happening in the future. For example, describing the provider's response to a previous safeguarding investigation, the registered manager told us, "I asked about 10 care staff to do the Care Certificate (a national care staff induction framework). To go back to basics. They all said

they would do it. But [the owner] wouldn't pay for [them to do it in work time] so some came back and said they found it too hard to match with their home life. Only about five or six completed." An opportunity to help some staff refresh their knowledge and practice had been missed.

More positively, since our last inspection we found the provider had taken action to improve the safety of staff recruitment. We reviewed staff personnel files and saw that references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the provider had employed people who were suitable to work with the people who lived in the home.

Since our last inspection, most staff had received training in safeguarding procedures. Reflecting this training, the staff we spoke with were aware of how to report any concerns relating to people's welfare, including how to contact the local authority or CQC, should this ever be necessary.

Inadequate

Is the service well-led?

Our findings

At each of our most recent comprehensive inspections of the home in May 2015, July 2016 and September 2017, we identified concerns with the auditing and monitoring of service quality and told the provider that improvement was required. Since July 2016, reflecting this shortfall in organisational governance, the provider had been in continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In response to our September 2017 inspection, the provider submitted an action plan dated November 2017 advising us that a 'robust new [medication] audit tool' had been introduced and 'all audits are being revised on how they [are] done, the result and what actions are being taken'.

However, at this inspection we found the provider had not complied with their action plan. The necessary improvements had not been made and the provider's approach to the auditing and monitoring of service provision remained ineffective. For example, although regular care plan, medicine and infection control audits were conducted by senior staff, they had failed to pick up the shortfalls in the individual risk assessment and care planning systems; infection control practice and the management of people's medicines we identified on our inspection. Additionally, in the light of the multiple health and safety hazards identified on our inspection, it was clear that the provider's approach to monitoring the safety of the premises and equipment was wholly inadequate. The provider's monthly 'audit checklist' had no record of any formal whole home environmental audit having been conducted in the first five months of 2018. Describing his approach in this area the registered manager told us, "[Since the local authority investigation] I have started daily walk rounds. Before, I'd go every other day. I started on Monday (two days before the first day of our inspection)." However, as described in the Safe section of this report, these 'walk rounds' had failed to identify numerous significant health and safety hazards throughout the home. For example, when our inspector took the registered manager to look at the unattached radiator cover and head board in one person's bedroom he said, "I didn't pick those up. Sorry." Similarly, when our inspector took the registered manager to the staff room to show him the multiple hazards inside, he commented, "I haven't been into the staff room [as] I don't have a break. [When I do] walk rounds, I don't go into the staff room."

We found another example of the continuing shortfalls in the provider's approach to monitoring the quality of the service when we reviewed the results of the provider's annual customer satisfaction. This was conducted with people living in the home, their relatives and staff. We reviewed some of the results of the most recent survey conducted in May 2017 and saw that issues highlighted by staff respondents included 'furniture needs replacing' and 'décor needs attention'. However, despite this feedback which was clearly accurate given the findings of our inspection some 13 months later, when we asked the registered manager to give us examples of what he had done in response to the survey, the only one he could offer was, "[Name of person living in the home] wanted ox tongue in their sandwiches. We did that for them."

At each of our most recent comprehensive inspections we rated the home as Requires Improvement reflecting shortfalls and breaches of legal requirements in areas including premises and equipment, medicines management and infection prevention and control. For over three years, fundamental shortfalls in organisational governance meant the provider had failed to deliver any sustainable improvement in the

quality of service. On this inspection, far from improving, we found the quality of the service had deteriorated and people were not receiving the safe, well-led service they were entitled to expect. The provider had not addressed either of the breaches of regulations found at our last inspection and was now in breach of a further regulation in respect of staffing.

The provider's persistent failure over several years to effectively assess, monitor and improve the quality of the service was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In preparing for our inspection, we reviewed the notifications (events which happened in the home that the provider is required to tell us about) we had received. We noted that, since the home was first registered with CQC in 2010, there had been very few notifications of a serious injury sustained by someone living in the home. When we discussed this issue with the registered manager he confirmed that in recent years there had been at least one serious injury sustained by a person living in the home which had not been notified to CQC, as required by the law. In the 12 months preceding our inspection, the provider had also failed to notify us of several allegations of abuse relating to people using the service which had been considered by the local authority under its adult safeguarding procedures.

The provider's failure to notify CQC of a serious injury and allegations of abuse was a breach of Regulation 18(2)(a) and (e) of the Care Quality Commission (Registration) Regulations 2009.

Similarly, in the months preceding our inspection, the provider had failed to notify us of the death of several people living in the home. This was a breach of Regulation 16(a) of the Care Quality Commission (Registration) Regulations 2009.

To his credit throughout our inspection, despite the many issues of concern we identified, the registered manager maintained an open and non-defensive approach. At one point he told us, "I will always be honest with you." Describing his leadership style, the registered manager told us, "My main goal is to make all residents happy and help staff be the best they can be. I wouldn't expect staff to do something I wouldn't do myself." The registered manager's caring approach was valued by his team. For example, one member of staff told us, "He's a really good manager. [If I have had] any issues he has sorted them out for me." Another staff member said, "[The registered manager] has been fantastic [with me]. He comes out of his office [and assists] if we need help with care [and] if we ever have problem I can approach [him]." Describing some of the things he did to promote the welfare and happiness of his team, the registered manager told us, "When they finish their NVQ, I buy them flowers. And we have a party for the staff at Christmas to say thank you."

Staff told us they worked well together in a mutually supportive way. For example, one staff member told us, "I enjoy [working here]. All of us get on. We've got good communication between us all." Another member of staff said, "I love it. We work as a team." Team meetings, communication logs and shift handover sessions were used to facilitate internal communication and in response to the recent local authority safeguarding investigation, the registered manager had scheduled additional 'emergency' staff meetings to discuss the initial findings. However, although staff told us they were happy in their work they also shared some of their concerns about the provider's approach to the overall running of the home. For example, one member of staff told us, "I think it is well run on care. I just think it is the cleanliness. It could be better on that side. And we do need an extra member of staff in the afternoon." Another staff member told us, "The staff are lovely [but] if I had a magic wand [I would improve] the cleanliness and the décor. And put another [member of staff] on in the afternoon." Talking with impressive candour about his own frustrations with the provider's approach, the registered manager told us, "To [the owner] it's about income and expenditure. He is assertive on staffing. He likes to have a percentage which goes to staffing and cleaning [and] it took something like

this (the local authority safeguarding investigation) to get him to do something. [You have seen] the state of the furniture and décor."

The registered manager told us that there were no links between the home and the local community, other than regular visits from a local church. The provider was a member of the National Activities Providers Association and on both days of our inspection we saw evidence of an active programme of activities. The registered manager told us that he was the 'dementia champion' for the home and attended external meetings to maintain and develop his knowledge of best practice in this area. The registered manager also told us that, following the local authority safeguarding investigation, his deputy would be taking on the role of infection control lead and would attend the regular infection prevention and control network meetings hosted by the local authority.

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 16 Registration Regulations 2009 Notification of death of a person who uses services
Treatment of disease, disorder or injury	The provider's failure to notify CQC of the death of service users.

The enforcement action we took:

We issued a fixed penalty notice of £1250.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider's failure to notify CQC of a serious injury to a service user and allegations of abuse of service users.

The enforcement action we took:

We issued two fixed penalty notices totalling £2500.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The continuing failure to properly assess and mitigate risks to people's safety.

The enforcement action we took:

We placed an additional condition on the provider's registration and cancelled the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The failure over several years to effectively assess, monitor and improve the quality of the service.

The enforcement action we took:

We placed an additional condition on the provider's registration and cancelled the registration of the registered manager.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to employ sufficient housekeeping and care staff to meet people's needs and to ensure compliance with regulatory requirements.

The enforcement action we took:

We placed an additional condition on the provider's registration and cancelled the registration of the registered manager.