Adbolton Hall Limited

Adbolton Hall

Inspection report

Adbolton Lane
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Adbolton Hall is a residential care home providing personal care to 24 people some of whom were living with dementia at the time of our inspection. Adbolton Hall can support up to 53 people across two floors, due to the number of people using the service and the state of disrepair of the first floor only the ground floor was in use.

People's experience of using this service and what we found
Infection prevention control measures were not in place and did not protect people from risk of harm. Staff were not recruited safely which left people at risk of receiving care from unsuitable people. Lessons were not learnt.

Medicines were not managed safely, and people were at risk of not receiving their prescribed medicines. People were not protected from the risk of harm or abuse. Staff did not recognise or report safeguarding incidents. Known risks had not always been assessed and risk reduction measures were either not in place or not followed.

People did not have their needs fully assessed and care was not delivered in line with best practice guidance and the law. This left people at risk of receiving unsafe care. People were not always offered choice in what they wanted to eat, or drink.

Although staff completed training in areas such as safeguarding and moving and handling, training was not effective, and people were not always supported safely. 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.

People did not receive personalised care and support. People were not offered choices in how they wished to spend their time, there were no activities on offer and staff did not engage in meaningful conversations with people. End of life care plans were not in place for people admitted to the home for end of life care and support.

People were not provided with consistently kind and caring support, they were not given choices or consulted about their care. Staff did not always support people in a dignified way, and they did not always acknowledge people who required support.

Governance systems in place did not identify the serious concerns we found. There was ineffective partnership working between the registered manager and provider which meant known issues had not been acted on. This meant people were at risk of receiving care which placed them at risk of harm in an unsafe environment.

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 requires improvement (published 24 December 2020).

Why we inspected
The inspection was prompted due to concerns received about staffing, training, management of risk and overall management of the service. 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.
The overall rating for the service has changed from requires improvement to inadequate.
We have found evidence that the provider needs to make improvements. Please see all 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 Adbolton Hall on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, staffing, fit and proper persons employed, person-centred care, dignity and respect and good governance.

We took urgent enforcement action to ensure people were kept safe from harm and placed conditions on the providers registration which meant they were not permitted to admit or readmit any new people to the service without the consent of CQC.

Follow up
We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 provider closed the service following after our inspection.

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 effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Adbolton Hall

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.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Adbolton Hall 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.
Adbolton Hall is a care home with nursing care. However, Adbolton hall had stopped providing nursing care at the time of our inspection. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

The registered manager resigned from their position after the first day of our inspection.

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 and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 15 people who used the service about their experience of the care provided and two relatives. We spoke with 12 members of staff including the registered manager, deputy manager, operations manager, senior care workers, kitchen staff, care workers and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with two professionals about their experience of the care provided at the home. We reviewed a range of records. This included six people's care records and multiple medicine records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including training records, policies and procedures were reviewed.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks were not assessed, managed or monitored in order to keep people safe from harm. Risks associated with people's healthcare needs were poorly managed.
- Risk assessments and care plans were either not in place or inaccurate for people living with skin damage and wounds. For example, a person with multiple areas of serious pressure damage had no care plan or risk assessment in place.
- Risks associated with falls were not accurately assessed or managed. For example, a person at high risk of falls did not have a risk assessment in place or any risk reduction measures in place. This placed people at risk of harm.
- Risks associated with the environment were not effectively managed and placed people at risk of harm. For example, the sluice door was found to be open and accessible for all people to enter, there was an open pipe which was found to be an open waste pipe. There were also hazardous substances for cleaning in the room. This placed people at risk of ingestion of hazardous waste and substances. We also found a number of fire doors to be faulty meaning they would not be effective if a fire occurred.

The provider failed to ensure risks were managed and monitored which placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not managed safely. This placed people at risk of not receiving their prescribed medicines safely.
- People did not always receive their prescribed medicines. For example, Medicine records for a person living with Parkinson's disease demonstrated there had been two occasions where they had not received their medicines. The medicine count was incorrect and there was excess stock present.
- People did not receive their prescribed medicine to ease pain when requested. For example, a person asked staff for pain relief, this was ignored for over forty minutes despite the person repeatedly asking. The inspection team intervened and found a member of staff to gain pain relief for the person. This placed people at risk of unnecessary pain and suffering.
- There were missing records relating to medicines which were required 'as needed'. For example, some of these medicines included rescue medicines for chest pain. This meant staff did not have instructions in how to safely give these types of medicines for each person or when to give them. This placed people at risk of harm.
- Medicines were not stored correctly or safely. For example, we found rescue medicine for chest pain in the managers office on top of a plug socket, staff did not know why it was there or for how long. We also found a

large amount of people's prescribed medicines to be stored on the floor of the office for at least five days, the room was not temperature controlled. This meant there was a risk medicines had not be stored at the correct temperature meaning they may not be effective for people receiving them.

The provider failed to ensure medicines were managed safely which placed people at risk of harm, this was 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
● People were at risk of infection due to poor infection prevention and control practices.
● The home was visibly dirty and there was a strong malodour throughout the home. Carpets and flooring in parts of the building were in disrepair and unclean.
● There were no risk assessments in place or guidance for staff in order to support people living with infectious diseases safely.
● Staff did not practice effective hand hygiene when supporting people. We observed multiple staff supporting different people, during lunch and whilst providing support in lounges, without sanitising or washing their hands. This placed people at risk of harm.
● The lack of infection and prevention control measures in place left people at risk of spreading and contracting healthcare related infections.

The provider failed to ensure effective infection prevention control measures were in place which placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was facilitating visiting in line with current guidance.
● The provider advised they had updated infection prevention control risk assessments for people following our inspection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems and processes in place did not protect people from the risk of abuse and neglect.
● Staff failed to recognise incidents as neglect and abuse. For example, we observed a person to be shouting out for help, in pain during lunchtime. Staff ignored these cries for help and at times laughed at the person. Staff failed to take any action to manage the person's needs. Staff failed to recognise this as a safeguarding incident. This placed people at risk of neglect and abuse.
● People told us they felt ignored by staff and were often left without their call bell so they could not call for help when needed. Our observations supported this, during our inspection we found a person nursed in bed had been left without their call bell. We also found another call bell cord in a bedroom had been cut and could not be reached.
● The provider failed to ensure staff recognised safeguarding concerns. This meant safeguarding concerns were not recognised, recorded or reported appropriately. This placed people at risk of continued abuse.
● Incidents were not always recorded or reported which meant lessons were not learnt when things went wrong. For example, a person reported they had fallen during the night, however the fall had not been recorded or reported to the management team. Additionally, we received a safeguarding concern from the ambulance service relating to an incident which had not been reported or recorded in a timely manner. This resulted in a delay in seeking medical attention. This placed people at risk of harm.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities)

Regulation 2014.

●The provider told us they had fixed the cut cord bell after our inspection.

Staffing and recruitment
● The provider failed to ensure there were always sufficient suitably qualified staff deployed to meet people's needs safely. Staff were recruited unsafely.
● We identified staffing numbers were not sufficient to meet people's needs or keep people safe. We observed people to be shouting out for support during the day. One person we spoke with told us, "I ask for help as I can't do it on my own and staff just don't ever come back, it's all the time."
● The providers own fire risk assessment stated four staff were required during the night to ensure people could be safely evacuated in the event of a fire. We found only two staff were allocated routinely during the night. This placed people at risk of harm.
● Essential safety checks such as references and a Disclosure and Barring Service check prior to starting employment were not in place for all staff at the time of our inspection. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The lack of safety checks placed people at risk of receiving unsafe care from unsuitable people.

The provider had failed to ensure sufficient staff were deployed at all times and failed to recruit staff safely. This was a breach of both regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

● After our inspection the provider told us, they had reviewed and increased their staffing levels.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were at risk of receiving unsafe care as their needs had not always been fully assessed. Not all people received a detailed assessment prior to moving into the service which left them at risk of harm.
● People's assessments contained inaccurate information about their needs. For example, a person who lived with multiple wounds due to pressure damage, had their skin assessed as 'content'. This meant staff did not have accurate information to safely support people which placed them at risk of harm.
●People told us they had not been involved in planning their care needs. For example, one person we spoke with told us, "I get no say in what care I get, I've never been asked since I got here."
● Care was not delivered in line with best practice standards and guidance. For example, best practice guidance relating to pressure area care was not consistently followed for people living with pressure damage and those at increased risk. This placed people at an increased risk of harm.

The provider failed to ensure people received care and support in line with their assessed need which placed people at risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's health needs were not managed effectively.
● Care plans did not contain sufficient information relating to people's health needs. For example, one person lived with multiple complex medical conditions, care plans did not adequately direct staff how they should support that person. Another care plan we reviewed for a person living with asthma, lacked information relating to asthma management. This placed people at risk of receiving unsafe care in relation to their healthcare needs.
● Staff did not always make referrals to health and social care professionals when specialist advice was needed. For example, a person admitted to the home for end of life care had not been referred to the specialist nursing team to ensure their needs could be met. Additionally, not all people who lived with pressure damage had been referred to a district nurse.
● When the service sought advice from healthcare professional's advice was not always followed. For example, advice from district nurses was not always followed.

The provider failed to work with other agencies to ensure people received timely care and support in line with their assessed need which placed people at risk of harm. This was a breach of regulation 12 (safe care

and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● An effective Induction and training programme was not in place for all staff.
● Whilst staff received training in areas such as infection prevention control, we observed that this was not effectively put into practice. We observed poor infection control practice from staff which placed people at risk of harm.
● The registered manager failed to take effective action to address poor staff performance and competence. This placed people at risk of receiving unsafe care.
● The provider failed to ensure staff received regular supervisions to identify any training or support. For example, some staff had received no supervision since starting their employment.

The provider failed to ensure staff were competent to provide safe and effective care this was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● People's rights under the MCA were not always respected.
● A person we spoke with raised concerns about their care and their understanding of why they had moved to Adbolton Hall. We fed this back to the registered manager who said, "They have been told over and over why they are here, maybe they don't have capacity." We checked the person's care records and there were no mental capacity assessments in place.
● Where people lacked capacity to consent, mental capacity assessments had not always been completed for specific decisions. For example, a person whose mental capacity was affected due to cognitive decline as a result of dementia had limited mental capacity assessments in place and no best interest decisions documented.
● DoLS were in place when required and conditions documented.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported effectively to eat and drink in order to maintain a balanced diet.
● During our inspection we observed people to have their food taken away without consultation. For example, we observed staff to take a full meal away from a person without asking why they hadn't eaten. The person told us they did not like what they had been given. We fed this back and staff provided an

alternative meal. After our inspection the provider told us they had implemented observations during mealtimes.

● People at risk of malnutrition had their weight recorded in order to monitor weight loss. Kitchen staff were aware of people who required their meals fortifying.

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

● Many bedrooms we observed were found to be bare and not decorated to individual taste or needs.

● A newly refurbished bathroom could not be used as it had not been designed to ensure people with mobility issues could safely get in and out of the bath.

● An activity schedule on display had an incorrect date of over five months. This placed people living with dementia at risk of disorientation.

● Some areas of the home had been adapted for those living with dementia. For example, toilet seats were a different colour. This ensured the toilet seat was easily recognisable for people living with dementia.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not treated well and with respect.
- We observed staff in the lounge to ignore a person's cries for help, staff spoke amongst each other whilst the person cried out for help to use the bathroom. Staff then said about the person, "I'm surprised [name] hasn't started moaning yet, [they] don't like it in here."
- People told us they felt staff did not always respect them. For example, one person told us, "Staff can't even get my name right, I've stopped telling them now." Furthermore, "Another person told us, "Staff ignore me, I ask for help and they tell me to wait, but sometimes I really need help there and then."
- Staff did not respect people's choices or preferences. For example, three people had asked for a specific gender to provide personal care and support for them. However, this was not respected, and people were routinely supported by staff of the opposite gender.

The provider failed to ensure people were treated well and respectfully. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- People were not treated with dignity and their privacy was not respected.
- Staff spoke loudly about people's personal care needs in the lounge in front of other people. For example, a person who required support with their continence needs had their needs shouted over the lounge. This did not respect people's right to privacy.
- We observed people to be left in undignified positions. For example, a person shouted for help as they had slipped down their bed and had parts of their body exposed, their bedroom door was wide open with people walking past. Staff approached the person and said, "I know, you need moving up your bed, but it takes two people, I'll go and find someone to help me move you." The bedroom door was left open and the person was visibly upset.
- We observed people to be wearing ill-fitting and dirty clothes, we found people who required support with personal care needs to be unkempt. For example, a person who required support to clean their teeth as detailed in their care plan had thick plaque on their teeth. This was undignified.

The provider failed to ensure people were supported in a caring, dignified and respectful way. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not always involved in making decisions about their care.
- We found people were spoken at rather than to. For example, we observed staff sat with a person who had communication difficulties, the person was trying to tell staff something. However, staff ignored their attempts to speak and said, "Oh you're mumbling." Staff then proceeded to speak to another person.
- Whilst staff sat with people, they made no attempt to talk and listen to people. The provider did not encourage people to express their views, we found no evidence of resident's meetings or feedback.
- Care plans we reviewed were inconsistent, some care plans demonstrated people and their relatives had been involved in planning their care. However, care plans for people recently admitted to the service did not evidence they or their relatives had been involved in planning care.

The provider failed to ensure people received care in a person-centred way. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People did not receive personalised care and support tailored to their needs and preferences.
- Care plans were not person centred and did not direct staff how to support people safely according to their needs. For example, care plans for people who lived with a complex mental health condition failed to instruct staff how to care for them to ensure their needs were met.
- People were not always supported and encouraged to make their own decisions and choices. For example, we observed people were taken into the lounge and left there in front of the television, no one was asked if they wanted to go to the lounge or what they would like to watch. Additionally, a person we spoke with told us, "I would like to go to the shop to get some fresh air, I've asked but staff tell me they don't have time."
- Care plans relating to end of life care lacked detail and some contained contradictory and undignified language. This placed people at risk of not getting the support they require or want at the end of their lives.
- A person who had been admitted to the home for end of life care did not have an end of life care plan in place. The person told us, no one had spoken to them about their needs or wishes. This meant staff did not have any information in order to provide care according to their needs and preferences.

Meeting people's communication needs

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

- Care plans detailed how people communicated and how staff should support them. However, we found staff did not follow care plans in order to support people with their communication needs.
- We observed staff to ignore a person with communication difficulties and they made no attempt to help the person communicate their needs. This placed people at risk of not having their needs met.
- There was limited information available to aid people's communication such as large print menus or pictorial prompts.

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 were not provided with enough meaningful activities to ensure they were mentally and physically stimulated.

● During our inspection people told us they were bored, and our observations supported this. One person we spoke with told us, "It's just so boring, there is nothing to do, I'm just so lonely."
● We observed people to be sat for long periods of time without any staff interaction. Staff sat with people in lounges but failed to engage with people, one staff member having sat in silence for over twenty minutes then shouted to another, "Can you take me out of here now."
● There were no activities on offer during our inspection due to the activity co-ordinator being off work. During our first day of the inspection no staff attempted to engage in any activity with people. However, on our second day of inspection one staff member went searching for games to play with people.

The provider failed to implement care to ensure people's personal preferences and needs were met. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place however we found that no complaints or concerns had been documented. This was not in line with information we had received.
● We raised a number of concerns and complaints with the registered manager prior to our inspection and received assurances these had been investigated and resolved; however, we found no evidence an investigation had taken place.
● The provider was receptive to the concerns we raised during our inspection and took some action in order to improve the quality of care provided.

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.

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

- The culture was not person centred, open or inclusive. This meant people were at risk of receiving poor care.
- The registered manager told us they did not feel supported in their role. For example, the registered manager raised concerns with the provider about staffing levels within the home prior to our inspection and limited support was given.
- Not all staff felt they could raise concerns and when they did, they did not feel listened too. Staff told us, "When I've raised things before, they don't listen, and things stay the same."
- The culture of the home had resulted in a high turnover of staff. This had a negative impact on the quality of care people received. For example, people told us, "My favourite staff have left, I stay in my room now as it's not the same."
- There were no meetings held with people, their relatives or staff to discuss the service. People and their relatives told us they had raised concerns particularly about staffing levels but had never been given any feedback from the management team.
- Staff meetings or supervisions were not regularly held. This meant staff were not given the opportunity to voice concerns or share ideas in order to improve the quality of care provided.

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

- There was a lack of effective managerial oversight of risk. The internal quality assurance processes had not been used to monitor the service effectively which resulted in poor care and an increased risk of avoidable harm.
- Audits were not effective in driving service improvement. For example, audits relating to infection control, the environment and medicines had failed to identify the significant concerns we found during the inspection.
- Lack of managerial oversight of care records meant these were not consistent. Care plans did not always provide staff with accurate information in order to support people safely. This risk was heightened due to the staffing issues at the home.
- The registered manager was aware of their legal requirement to notify CQC of events and incidents which impact people. However, we found they had not always been open and honest in the information they provided. For example, we received a notification relating to a wound stating what risk reduction measures

were in place to reduce the risk, we found that these risk reduction measures were not all in place.

The provider failed to learn, monitor and improve the quality and safety of care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider was aware of their responsibility to investigate, share information and apologise when things went wrong. However, the lack of provider oversight meant they could not be assured all incidents had been fully investigated by the registered manager.
- People and their relatives told us they were informed when incidents occurred. A relative we spoke with told us staff phoned them to apologise when their relative sustained a fall.
- The provider told us they planned to speak with all people and their relatives following our inspection.

Working in partnership with others

- Staff did not always seek specialist advice from health and social care professionals in a timely manner. When advice was sought this had not always implemented effectively. This meant people were at risk of avoidable harm.
- A professional we spoke with told us, they felt staff required further support and training in pressure area care in order to minimise the risk to people. Furthermore, they told us, they had fed this back to the senior management team and felt confident they would address the issues they had raised.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care and support which left people at risk of harm.

The enforcement action we took:
We imposed urgent conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always supported in a dignified or respectful way.

The enforcement action we took:
We imposed urgent conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at significant risk of harm from poor risk management and their environment. Medicines management was poor. Infection control practices were not in line with guidance leaving people at significant risk of infection.

The enforcement action we took:
We imposed Urgent Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure there were adequate safeguarding processes and systems in place to

safeguard people from the risk of abuse and harm.

The enforcement action we took:

We imposed urgent conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure there was effective leadership in place. There were not effective systems and processes in place to assess, monitor and improve the quality of care.

The enforcement action we took:

We imposed Urgent Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to recruit staff safely.

The enforcement action we took:

We imposed Urgent Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was adequate staff with the right skills to meet peoples needs.

The enforcement action we took:

We imposed urgent conditions