Monarch Consultants Limited

Parkside Nursing Home

Inspection report

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

Summary of findings

Overall summary

About the service
Parkside Nursing Home is a care home that provides personal care and nursing for up to 50 people in one purpose-built building. At the time of the inspection 46 people lived at the home.

People's experience of using this service and what we found
Although many people told us they felt safe at Parkside, this was not reflected in our findings.

People were not protected from abusive practices, concerns had not always been reported and investigated and action had not been taken to keep people safe. Risks associated with people's care and support were not managed safely. Measures were not always in place to reduce risks such as choking, falls and pressure ulcers. This placed people at risk of harm.

There were not always enough staff to meet people's needs and ensure their safety. Furthermore, staff did not all know how to provide safe care. Consequently, their actions placed people at risk of harm. Medicines were not managed safely and the come was not clean and hygienic in all areas. Safe recruitment practices were followed.

People were at risk of inconsistent and unsafe care as their needs had not always been fully assessed and planned for. People's health needs were not managed safely or effectively. Good practice guidance and advice from specialist health professionals was not always followed.

People were not always supported by competent staff. Although staff had received training they did not always implement learning in areas such as safeguarding and behaviour management. Risks associated with eating and drinking were not managed safely and people's feedback about the food was mixed.

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. Support was provided against people's wishes and when people lacked capacity to make decisions there was no evidence that staff were providing support in the least restrictive way.

There was not a culture of person-centred care at the home. People were not provided with consistently kind and caring support, they were not always given choices or consulted with about their care. Staff did not always support people in a dignified way and aspects of the environment meant staff could not ensure their privacy. Staff did not always communicate with people in a respectful manner and were not always responsive to people's distress.

People were not consistently provided with support that met their needs and preferences and people told us there were not always enough staff available to respond to their requests for support. People were not

consistently provided with compassionate care at the end of their lives, care in the dedicate end of life unit was poor. People could not be assured concerns and complaints would be addressed. People were supported to keep in touch with their family and friends and had some opportunity for social activity.

The home was not well led. There was blame culture at the home and a lack of accountability for issues found. Although the registered manager was experienced and had a clear understanding of their role, they had not ensured the home was run safely or effectively. People's health and safety was risk due a failure to identify and address issues and due to poor practices by senior staff at the home. There was a lack of clinical governance and care documentation had been falsified.

Although we found that the service worked with partner agencies, people's feedback about working relationships was poor. Morale in the staff team was low, there was a culture of mistrust and this had a negative impact on the care people received.

The service met the characteristics of Inadequate in most areas. 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 19 May 2017).

Why we inspected
The inspection was prompted in part due to concerns received about safety, quality and leadership. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified seven breaches of the legal regulations. These were in relation to, dignity and respect, person centred care, consent, safe care and treatment, safeguarding, governance and staffing. Information about the action we have taken can be found at the end of this report.

Follow up
We will continue to monitor information we receive about the service. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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 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 always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Parkside Nursing 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 Care Act 2014.

Inspection team
This inspection was carried one inspector, a specialist nursing advisor, an assistant inspector 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. Representatives from the local authority and NHS Clinical Commissioning Group were also present on the first day of our inspection.

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

At the time of inspection, the service had a manager registered with the Care Quality Commission. The registered manager left their post during the inspection period. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

We did not ask the provider to complete a Provider Information Return (PIR). This is information we require

providers to send us to give key information about the service. We gave the provider and registered manager the opportunity to share this information during the inspection.

During the inspection-
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with seven members of care staff and the nominated individual, regional manager, registered manager, two nurses, catering and housekeeping staff.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, three staff files and the staff duty rota. We looked at documentation related to the safety and suitability of the service and spent time observing interactions between staff and people within the communal areas of the home.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

● People were not protected from abuse. During our inspection we found evidence that people were subject to unnecessary control and restraint. Staff told us they had observed other staff using physical restraint, for example, staff holding a person's arms. During our inspection we saw a member of staff use physical force against a person to manage their behaviour, this was a form of restriction which did not respect their rights and may have caused injury.

● Action had not been taken to report and investigate allegations of abuse. Staff failed to report serious safeguarding concerns. A person's relative had witnessed an incident of staff goading a person and using inappropriate physical force against them. They had reported this to members of staff. Despite this, there was no evidence that staff had shared the concerns and they had not referred to the local authority safeguarding adults team. Consequently, no action had been taken to ensure people's safety.

● Action was not taken to record and investigate unexplained injuries. Several people had unexplained bruising and skin tears. There were no records of these injuries and no investigations had taken place to identify the cause. The failure to record and investigate unexplained injuries meant unsafe or abusive practices may not be identified.

● Some staff told us they did not have confidence in the registered manager to act upon reports of abusive practices.

● Before and during our inspection, concerns were raised that some people were 'bullied' by staff. This was under investigation by the local authority safeguarding team at the time of our inspection.

The failure to protect people from improper treatment and abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People were at risk of harm because risks associated with their care and support were not safely managed. Risks such as falls, choking and pressure ulcers had not always been assessed and measures were not always in place to reduce risk. For example, one person had been living at the home for two weeks. Despite being at risk of choking and requiring oxygen therapy, they did not have any care plans or risk assessments in place. Consequently, staff did not have a good understanding of their support needs. This failure to assess and manage risk placed people at risk of harm.

● People were at risk of harm due to poor moving and handling practices. We observed several people being lifted by their armpits or pulled up by their clothing or hands. These are not safe techniques and placed people at risk of harm.

● Equipment was not always used safely. There was a risk of some people becoming trapped in bedrails and several pressure relief mattresses were not set correctly so may not have been effective in reduce the risk of

pressure ulcers.

Using medicines safely

● People experienced suffering and distress as was pain was not managed effectively. We saw a person was shouting out in pain. Staff were present in the unit but did not respond, consequently action was not taken to give them additional pain relief as prescribed. The lack of response to, and understanding of, pain management exposed the person to unnecessary pain and distress.

● People were at risk of not receiving their medicines as prescribed. Medicine stock levels were not correct. There was excess medicine in stock for some people and missing medicines for others. This meant it was not possible to tell if people had received their medicines as prescribed. The provider was aware of this and was seeking support from external partners.

● Safe medicines administration processes were not followed. We found a medicine in a person's bed. The person required staff to ensure their had taken their medicines. Staff had not followed guidance, so were not aware that this medicine had been missed until we brought it to their attention.

Learning lessons when things go wrong

● Opportunities to learn from incidents and improve practice had been missed. One person required constant supervision due to a high risk of falls. There had been a recent incident where they were left alone in their bedroom and tried to mobilise, placing them at risk. Effective action had not been taken to prevent this from happening again. During our inspection, we found they had again been left unattended and tried to mobilise. This placed them at risk of harm.

● Incidents such as falls, choking and behavioural incidents were not recorded properly by staff. This meant the registered manager was not aware of some incidents, or there was inadequate detail to enable proper investigation. This increased the risk of the same thing happening again.

Preventing and controlling infection

● People were not protected from the risk of infection. Some areas of the home, including people's bedrooms, were not sufficiently clean. Some areas were odorous, and we found equipment which had been penetrated by bodily fluids. This did not promote the control and prevention of infection.

The failure to ensure people were provided with safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Despite our findings most people and their families told us they felt the service was safe. One person told us, "I have felt very safe and protected in here." A relative said, "It is very safe here, now I can sleep at night."

Staffing and recruitment

● There were not always enough competent staff available to meet people's needs and ensure their safety. This was reflected in feedback from people. One person told us, "Well there are never enough of them (staff). In fact, there is never anyone about." A relative told us, "You never know how many (staff) will be on duty." Staff told us there were often times when short notice staff absences meant there were not enough staff to safely meet people's needs. Records showed this was the case.

● Staff were not always given sufficient information or training to ensure people's safety. A member of agency staff was on shift during our inspection, they had not seen the care plans for anyone they were caring for. This meant they had a poor knowledge of people's needs. For example, they were unaware that one person needed thickened fluids and consequently they had served the person a drink at the wrong consistency. This placed the person at risk of choking.

The failure to ensure there were enough, competent staff available to meet people's needs and ensure their safety was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practices had been followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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 inconsistent and unsafe care as their needs had not always been fully assessed and planned for. Assessments were not always fully completed upon admission to the home. Consequently, staff were not always aware of key information such as use of pressure relieving equipment, behavioural issues and medicines people were taking.
- Although nationally recognised approaches such as risk assessments were used they were not always in place and guidance was not always followed. For example, one person had been assessed as being at high risk of falls. Despite this no measures, such as assistive technology, had been put in place to reduce the risk of them falling.

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

- People's health needs were not managed safely or effectively. People's care plans did not contain adequate information about their health needs and consequently staff did not provide the support people needed in this area. For example, one person experienced seizures. Although they had not experienced a recent seizure their care plan did not document action to be taken in the event of a seizure or provide any information on possible triggers. This meant if the person were to have a seizure they may not receive the support they required.
- When people had wounds there were not always records in place and wounds were not dressed as regularly as required. This posed a risk to people's health.
- Referrals were made to external health professionals when required, for example, specialist nurses, opticians and GP's. However, advice was not always incorporated into care plans and consequently staff did not follow guidance. For example, a speech and language therapist had recommended a specific diet for one person, this was not in their care plan and staff did not provide the person with the correct consistency food.
- There was a risk information may not be shared when people moved between services. A lack of care plans for some people and variable staff knowledge of people's needs meant sufficient information may not be available if people were transferred to hospital in the event of an emergency. This meant people may not receive the care they required.

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

- Risks associated with eating, such as choking were not managed safely. Some people had lost significant amounts of weight, but action had not always been taken to increase monitoring nor was there any

evidence of them being referred to external health professionals. This posed a risk of people losing further weight.

The failure to protect ensure people were provided with safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback about the quality of the food was mixed. One person commented, "The food is passable." Another person said, "I like things hot and when they bring you anything it is always lukewarm." We observed food was left standing for periods of time, resulting in it not being hot when served.
● People were not offered a choice of food but alternative options were made available to people when requested. Drinks were available to people and these were left within people's reach. Records were in place to monitor people who were at risk of dehydration.

Staff support: induction, training, skills and experience
● People were not always supported by competent staff. This was reflected in feedback from people and families. One person told us, "New staff don't seem to have had virtually any training at all."
● Although records showed staff had training in keys areas, such as safeguarding and moving and handling, this had not always led to competency. For example, staff told us and records showed staff had training in safe ways to manage high risk behaviours. During inspection, we observed staff were not implementing learning from their training and were instead using improvised approaches that placed people at risk of harm.
● During our inspection we identified concerns about the practice of senior staff who provided training and induction to staff. This meant we were not assured staff training was based upon good practice.
● New and temporary staff did not always have an effective induction to their role. During our inspection we found temporary staff had only been given a basic induction to the building, they had not been given access to care plans or records and had not been provided with important information such as codes to doors. This meant they did not have any knowledge of the people they supported and were unable to move around the building.
● Staff did not always feel supported. Staff feedback was mixed in this area, some told us they were well supported, however, others told us they did not have regular supervision and did not feel they could go to the management team for support. Records showed some staff had not had regular opportunities to meet with their manager. This meant opportunities to support staff and monitor performance may have been missed.

The failure to ensure staff were competent to provide safe and effective care was a breach of regulation 18 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

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

● People's rights under the MCA were not always respected. Care was provided against people's wishes as people with capacity were misled to get them to accept care. For example, staff told us one person had capacity to consent to all areas of their care and treatment. Despite this, the registered manager had advised staff to encourage the person into their wheelchair, not telling them they were going in the shower. Then staff would take them to the bathroom for a shower without their consent. A member of staff said, "If [name] declines we are still forced to do it against their will." This did not respect the person rights.
● Where people were subject to restrictions, such as physical intervention, their capacity to consent had not been assessed. Consequently, there was no evidence that interventions were the least restrictive option or in their best interests.

The failure to respect people's rights under the MCA was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DoLS were in place when required. None of the DoLS we viewed had any conditions imposed.

Adapting service, design, decoration to meet people's needs
● The home was adapted to meet people's needs. Aids and equipment had been installed throughout the home to enable people with mobility needs to navigate around the building. Calls bells were available in each bedroom so people could request support.

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

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

- People were not consistently involved in decisions about their care and support. One person told us, "I don't need any choices, they choose for me." A relative commented, "[Name] can't make any choices, but we trust the staff to do what they should for them." This was reflected in our observations, some staff took time to offer people choices, but others did not.
- People and families were not always involved in planning their care and support. Several people who had recently moved in had no care plans in place. This meant they had not had any formal opportunities to discuss how they wanted their care to be delivered. A relative told us, they had not been involved in any care planning and said, "I really feel worried that there seems to be no structured plan of care for [name]."

Respecting and promoting people's privacy, dignity and independence

- People were not always provided with care that promoted their dignity. Staff did not always notice or attend to people's personal care needs. One person was reliant upon staff to maintain their personal appearance, however staff had not provided this support and they were left in an undignified state.

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

- There was not a culture of person-centred care at the home. Although people were, overall, positive about individual staff, this was not embedded in the culture or leadership of the home.
- Staff did not always communicate with people in a kind and compassionate manner. One person was in pain and had requested additional pain relief. A member of staff stood by the person's bed and stated, "We have some end of life meds for [name]." The member of staff did not consider the impact this may have had upon the person's wellbeing. Action was taken following our inspection to address this.
- Staff did not always respond to people's distress. We observed a person calling out in pain, a member of staff was sat in the room next door and did not respond to their calls. On another occasion a person became frightened about another person's behaviour. Staff did not respond to their upset until we prompted them to do so.
- People were sometimes supported by staff who did not know them. One person told us, "The new staff don't even introduce themselves to you so you never know who they are." We observed this to be the case during inspection. Some people did not have care plans so staff had to learn about people "on the job", other staff told us they had not read care plans so did not what was important to people or how best to support them.

The failure to treat people with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the above findings, the majority of people who could communicate their views told us most staff were kind and caring. One person told us, staff were, "Very, very caring." This was also reflected in feedback from people's relatives, a relative commented, "Staff are 100% kind and caring."
● Staff respected people's diverse needs in some areas. For example, it was clear people felt comfortable to express their sexuality and this was supported by staff.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people's needs were not always met. 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

● People were not consistently provided with support that met their needs and preferences.
Some people did not have care plans in place and other care plans did not reflect people's current care needs or were contradictory. This meant staff did not have clear guidance about how to support people. For example, one person's care plan was contradictory. A member of staff told us, "I have read the care plan, but I still do not know how to support [name]." This posed a risk that people would be provided with inconsistent support that did not meet their needs or ensure their safety.

● People told us there were not always enough staff available to respond to their requests for support. One person said, "It's almost sacrilege to ask to go to the toilet. You almost feel afraid to ask." This was supported by feedback from staff. A member of staff told us they were not always able to provide the care everyone needed in a timely manner. This meant people's needs were not always met.

End of life care and support

● People were not consistently provided with compassionate care at the end of their lives. The home had a unit dedicated to the care of people who were coming towards the end of their lives. However, we found the care on this unit to be of poor quality. Staff did not always have a good understanding of people's needs they did not always respond to people's distress and wound care and pain were not managed effectively,

● End of life care planning was of variable quality. Some people only had very basic information in place. For example, one person's plan stated they wished to be 'comfortable and free from pain.' There was no personalised information about how this would be achieved. Other care plans had not been completed. For example, one person's care plan stated 'awaiting family input', this had not been reviewed since May 2019. This posed a risk people may not get the support they required at the end of their lives.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People were not always given information in a way they could understand. For example, staff told us, and we observed that although some people had a cognitive impairment, people were only offered verbal

choices and no other resources, such as photos, were used by staff to communicate with people.
● Care plans did not always contain clear information about how people communicated. One person's care plan stated they could become confused and anxious. There was no guidance about what the person may be trying to communicate, or how staff should communicate with the person to reduce their anxiety. This posed a risk staff may not respond appropriately when people used their behaviour to communicate.

Support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were offered some opportunities for social activity. The provider employed two activities coordinators who planned a range of activities such as games, crafts and external entertainer. During our inspection activities were minimal, many people were unoccupied for long periods of time. The activity coordinator told us staffing levels impacted on their ability to offer activities. They said, "I am supposed to do activities but when they are short, like today, I have to do caring instead'.
● Staff did not always take natural opportunities to chat and engage with people. When staff had spare time they either completed records or talked with each other.
● We were not told about any trips out of the home into the community or community involvement within the home.

The failure to ensure people were provided with person centred care and support was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Complaints and concerns were not always handled in accordance with the providers complaints policy. Prior to and during our inspection, some people and relatives told us they had raised complaints about practices at the home. However, the registered manager told us there had been no complaints in 2019 and there were no records of recent complaints in the complaints log. A relative told us they had raised concerns previously and said, "In the end nothing happens, and it comes down to us keeping an eye on [name] and making sure that the staff do what they are supposed to do."
● There were no records of concerns raised by people, families or staff. Several people and staff told us they had raised concerns informally. Although the provider had a specific process for handling concerns this had not been followed and there were no records of concerns raised or action taken. This meant we could not be assured timely action was taken to resolve concerns and complaints.

Supporting people to develop and maintain relationships to avoid social isolation;
● People were supported to maintain relationships with people who were important to them. Throughout our inspection we saw people's families were welcomed into the home. One relative told us they were often invited to stay and have a meal with their family member.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

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

- There was blame culture at the home and a lack of accountability from the registered manager and the provider. Issues found throughout inspection were attributed to individual members of staff, rather than looking at service wide issues such as leadership and quality assurance processes. For example, we shared concerns that an agency worker did not know about people's needs as they had not been given access to any care plans. The provider stated they would ask not to have that member of staff again, rather than looking at what could be done to improve their systems for sharing information.
- The culture of the home had resulted in low staff morale and a high turn over of staff. This had a negative impact on the quality of care people received. For example, we found people were being supported by staff who did not know them.

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

- Although the registered manager was experienced and had a clear understanding of their role, they had not ensured the home was run safely or effectively.
- People's health and safety was risk due to poor practices from senior staff at the home. Prior to our inspection we received concerns alleging the falsification of documentation. During our inspection, we found evidence that the registered manager and other senior staff had falsified wound. Consequently, action was taken to report their practice to the Nursing and Midwifery Council. This poor practice by senior staff had a negative impact upon people's health and wellbeing.
- The registered manager did not take action to follow up safeguarding concerns. A relative had reported an allegation of abuse to a member of staff. Although we informed the registered manager about this at approximately midday on the first day of inspection, they did not take action to find out more until we asked them to do so at approximately 5pm. This failure to act had resulted in a failure to protect people from abusive practices.
- The registered manager did not oversee the conduct of, or ensure information was shared with agency workers, this had resulted in poor care. The registered manager did not accept responsibility for this issue and told us it was due to our inspection.

Continuous learning and improving care

- There was a lack of effective clinical governance. This resulted in systematic issues with the management

of risk and health conditions detailed in this report. These failings had a negative impact upon the care and support people received and placed them at risk of harm.
● Swift action was not taken to address know issues. The provider had completed an audit at the home two weeks before our inspection. This audit had highlighted a range of issues including safeguarding, staffing and care planning. The registered manager did not take ownership of the issues and attributed failings to a member of the management team who had since left. Despite some of the actions being highlighted as urgent for immediate action, these issues remained at our inspection.
● Effective action was not taken to address risk. After the first day of our inspection we wrote to the provider detailing our concerns and asking them to take urgent action to address the issues and reduce risk. The provider submitted a clear and detailed action plan. Despite this, when we returned to the home we found the actions taken had not been effective in reducing risk, we also found new areas of risk that again, had not been identified by the provider or registered manager. Failure to address the issues found exposed people to the continued risk of harm.

Working in partnership with others
● Although we found that the service worked with partner agencies, people's feedback about working relationships was poor.
● Health and social care professionals had raised concerns about the attitude and approach of the registered manager, there had been incidents where the registered manager had challenged the competency and experience of external professionals in a way that had made them feel uncomfortable.
● We were also informed about an incident at another care home where the registered manager had talked in a derogatory way to a member of staff employed by another provider. This did not promote good partnership working and could have a negative impact upon people's care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Although staff were given the opportunity to provide feedback about the running of the home, in surveys and meetings, effective action was not taken to address issues raised. For example, concerns had raised about staffing levels. The registered manager had responded to this stating staffing levels were always maintained, but there can be a perception there are not enough staff. This did not address the issue and we found concerns about staffing levels during inspection.
● Staff did not feel they were treated equally. Before and during our inspection, staff told us the registered manager did not treat staff equally or fairly. Staff told us about times they had reported concerns where seemingly no action was taken, but also said action was taken against other staff for relatively small issues. Some staff told us the registered manager was often rude and abrupt and they no longer felt they could go to them to raise concerns.
● Staff told us they had concerns about confidentiality. They shared examples of where they had confidential conversations with the management team, the content of which was then disclosed to others. This had created a culture of mistrust.

The failure to ensure good governance and leadership was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their families told us they had been invited to meetings to share their views about the home. Records showed these focused areas such as on activities, food and staffing.
● The registered manager had notified us of events as legally required.
● It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. The provider had displayed their most recent rating in the home.

● After our inspection visits, the provider informed us they had enlisted the support of consultant to support them to improve the safety and quality of service provided. They provided an action plan stating how improvements would be made. The registered manager left the home and a new management structure was implemented. We will assess the impact of this at our next inspection.

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 9 HSCA RA Regulations 2014 Person-centred care People were not provided with person centred care and support hat met their needs or reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act (2005) were not respected. People were provided with care against their will. Regulation 11(1)

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 Risks associated with people care and support were not managed safely. Regulation 12(1)

The enforcement action we took:

We took action to restrict admissions to the home and imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the safety and quality of the service were not effective. Action was not taken to address issues. Regulation 17(1)

The enforcement action we took:

We took action to restrict admissions to the home and imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough competent staff available to meet people's needs and ensure their safety. Staff did not have adequate training and support to ensure their competency. Regulation 18(1) (2)

The enforcement action we took:

We took action to restrict admissions to the home and imposed conditions on the registration of the provider.