Sanctuary Care Limited

Garside House Nursing Home

Inspection report

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19 December 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Garside House Nursing Home is a residential care home that provides personal and nursing care for up to 40 people on three separate floors. At the time of the inspection 27 people were living at the service, including older people, people living with dementia and those receiving end of life care.

People's experience of using this service and what we found
People were placed at undue risk of harm. People were unable to easily call staff for assistance when they needed it. Risk management plans were not always followed correctly to mitigate the risk of harm. People's medicines were not managed safely. The service did not always follow good infection control procedures.

Care plans did not always meet all people's health and social care needs. People's hydration needs were not always met and the risk of dehydration and weight loss was not properly mitigated.

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 told us their regular staff were kind and caring and treated them well. The frequent use of agency staff impacted on people's experience of care. Some practices in the service compromised people's dignity.

People and their relatives did not contribute to the formation and review of their care plans and these were not always individualised to meet people's personal preferences. People's social needs were not adequately met and the risk of social isolation was not mitigated. End of life plans were not in place for people.

The service did not engage in a meaningful way with people receiving care and their relatives. Systems were in place to monitor the quality of the service however they had not identified all the concerns raised in this inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The rating for this service was Requires Improvement (published 29 March 2019).

Why we inspected
The inspection was prompted in part by notification of specific allegations of abuse and mistreatment of people receiving care which we received on 21 October 2019. The local authority visited the service shortly after these allegations were received and raised further concerns of safety and good governance which prompted our inspection of the service. The original allegations are subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the specific allegations.

Enforcement
We have identified breaches of regulation in relation to safe care and treatment, safeguarding people from abuse, person centred care, dignity and respect, nutrition and hydration, staffing, acting on complaints and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below

Garside House 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
The inspection was carried out by two inspectors, an inspection manager 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 service.

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

The service does not have a manager registered with the Care Quality Commission. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection, the manager was one of the staff members that had been suspended due to the serious concerns that had been received. The provider had placed a peripatetic manager at the service to manage in their absence. Throughout this report we will refer to them as 'the manager'. The local authority had also placed a 'step-in' team to observe practices and identify ongoing risks to people due to concerns they had with safety and the management of the service.

Notice of inspection
This inspection was unannounced on the first day. The provider knew we would be returning on subsequent

days.

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 prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 12 people who used the service and three relatives. We spoke with nine members of staff including two peripatetic managers who had been temporarily placed at the service. We also spoke with three nurses, a care assistant, two maintenance managers and an activity coordinator. We made general observations of the care people received and interactions between staff and people receiving care.

We reviewed a range of records. This included 10 people's care records and multiple medicines records. We looked at seven staff files in relation to recruitment and supervision. We also reviewed records related to the management of the service, which included policies and procedures, complaints, accidents and incidents, quality assurance audits and safeguarding records.

After the inspection
We continued to seek clarification from the provider to validate evidence found in relation to people's care and support, staff training and quality assurance processes. We spoke with five more members of staff including a nurse, two care assistants, an administrator and the assistant chef. We also met with the nominated individual, the director of nursing, quality and care and the regional director to discuss the issues we identified during the inspection and considered their plans for improvement. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- The provider did not have a systematic way of determining the staffing levels to ensure people's needs were safely met. The manager informed us the local authority contract stipulated the minimum staff levels during the day were three nurses and nine healthcare assistants. The minimum staffing levels (based on full occupancy of the service) during the night were three nurses and four healthcare assistants.
- Analysis of a recent rota showed that the staffing levels had recently changed so that only two nurses were on shift during the night. At the time of our inspection the manager could not explain why this decision had been made, however the provider has since told us that the reduction in nurses during the night was based on the number of vacant beds and when they reduced the number of nurses during the night they had increased the number of health care assistants. The provider has also informed us that they have now reinstated three nurses to cover the night shift.
- We also found numerous instances when the number of care assistants and nurses on shift during the day fell below the stated minimum levels. The provider told us that these shortages were caused by staff sickness at short notice. This meant the contingency plans for staff cover were not always sufficient to respond to emergencies and ensure enough staff were on duty at all times.
- Due to staff shortages the service was using a high number of agency staff and people told us this impacted on the safe care they received. One person told us, "There have been times when none of the carers or nurses are familiar. I had to explain everything as they had no hoisting experience.

The failure to ensure there were sufficient suitably qualified staff on duty at all times placed people at risk of harm was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service followed safe recruitment processes. There was a system in place to ensure that all pre-employment checks were completed before staff started work. Checks included people's right to work in the UK, employment history, references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

- There were not sufficient systems in place to protect people from the risk of neglect. Most people using the service had complex health needs and were not able to call for assistance from staff if they needed it. The manager informed us they had recently moved the location of some of the call bell cords to ensure people could reach them. However, during our inspection we observed call bell cords were out of reach for several people, meaning they would be unable to call for help in an emergency or if they needed assistance.

● Some people had call buttons on a wrist strap but when we asked if they worked they told us staff took a long time to respond. We asked one person to demonstrate this and when they pressed their call button no staff came to offer assistance despite several attempts and waiting for 10 minutes.
● Records showed that 20% of staff had not received training in safeguarding adults so the service could not be sure they would be able to recognise and respond to signs of abuse and neglect.

The lack of robust systems and processes to safeguard people from abuse placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Although people and their relatives told us they felt safe with the care provided, we identified people were not always protected from potential harm. Risks to people's health and wellbeing were not always identified, assessed or mitigated. For example, the service had not identified the potential risk of harm from call bells cords. Although we identified that some people could not reach these cords the provider had not considered the potential risk of accidental or intentional ligature.
● During the inspection we observed practices that put people at risk and had not been identified by the service. For example, we saw unidentified thickener left in two communal dining areas near the tea and coffee station. Thickener is used to thicken drinks for people with swallowing difficulties. This was accessible to service users, and the accidental use of this type of thickener by someone not prescribed it put service users at risk of choking.
● There were a range of checks and audits on the equipment and maintenance of the building including regular fire safety checks. However, during the inspection, we found an external area that was designated as no smoking showed signs of smoking with discarded cigarettes. The risk of fire was increased further as there were oxygen cylinders being stored nearby.

Using medicines safely
● Medicines were not managed safely and there was a lack of checks and measures to ensure errors and potential risks were identified. During and after the inspection the provider informed us of eight serious medicines errors that had been discovered by the local authority or the temporary peripatetic nurse manager. The number of medicines errors showed a widespread lack of oversight and leadership in the safe management of medicines.
● During our inspection we found topical creams were being stored in unlocked cabinets of people's rooms, which were easily accessible, and was therefore a risk of accidental ingestion which had not been assessed. The administration of topical creams was not being recorded. During our inspection, a lead nurse put in place topical creams charts to record the application of all topical creams. The charts did not contain sufficient information for care staff and were not being used consistently to evidence creams had been applied. We also found topical creams were consistently not marked with a date of opening, which put people at risk of using medicines that were not effective.
● Some people who had difficulties swallowing were prescribed thickener to reduce the risk of choking. The individual guidelines for these were not available for staff so we could not be sure people were getting the correct level of thickened fluids.
● Some people were prescribed transdermal patches which are applied to the skin to deliver pain relief medicine to alleviate chronic pain. The recording and application of the patches was not carried out to agreed guidelines. We also saw an example where a member of staff had recorded that they had observed and removed a patch of the wrong dose that had been applied previously. There was no record that this medicines error had been reported or dealt with appropriately.
● The medicine stock management system was not effective. On 11 November 2019, several people's supply

of medicines had run out and emergency supplies were needed. One person affected was not given their morning dose of diabetes and blood pressure medicine due to the delay in obtaining a new supply. When we spoke with the person they told us this had happened several times before causing them to miss their medicines or have them later than prescribed.

Preventing and controlling infection

● The service did not manage infection control safely. On the first day of our inspection we found fridges on the second floor were storing food that had not been labelled with a date of preparation. The temperature of the fridges was also not being recorded to ensure they were at a safe temperature to stop the growth of bacteria. Due to this lack of safe storage and monitoring there was a risk that people may be given food which was out of date or not stored safely.

● Staff told us that the personal protective equipment such as gloves and bags for soiled laundry that were supplied were of poor quality and often split during use. We corroborated this during our inspection and found the gloves split easily when put on, meaning that there was risk of contamination to people receiving care and staff members when doing personal care or handling contaminated substances.

The failure to have an effective system in place to identify and mitigate risks, manage infection control, and medicines safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There was a system in place to record accidents and incidents when they occurred. All reported accidents and incident were reviewed by the manager who was responsible for taking the appropriate action to ensure people were safe and necessary precautions were taken to stop a reoccurrence of incidents.

● However the process for reporting accidents and incidents was not effective as we were informed of several medicines errors that had not been recorded and analysed.

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 Requires Improvement. At this inspection, this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff did not receive adequate support and training to ensure they were equipped to meet the needs of people using the service. The training matrix that was supplied showed that not all staff had received the necessary training in moving and handling, safeguarding adults, end of life care and fire safety. This lack of training was impacting on people's care and support as the provider could not be sure that enough staff were on duty to conduct safe moving and handling in and out of bed. Staff also did not recognise the potential safeguarding issues of neglect and medicine errors that we found during our inspection.
- Staff told us they felt supported by their manager and had regular supervision. However, records we saw showed that this was not the case for all staff. A staff supervision matrix showed that 11 staff members has not had supervision from their manager in 2019.

The failure to ensure staff were supported and had the necessary training was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service did not ensure that people who were at risk of dehydration had enough to drink. We saw a range of care plans that identified people were at risk and stipulated a minimum amount of fluid per day and guidance for staff to record the amount. We found numerous occasions where people had not achieved their target amount and no further action had been taken or followed up with the relevant health and social care professional.
- A relative told us their family member had recently been admitted to hospital due to dehydration after several days of sickness and their care records confirmed they had not received their target amount of fluid.
- We also saw examples of people at risk of weight loss that were not being well managed. One person's plan showed they weighed 44kg and they were prescribed a nutritional supplement to help them gain weight. However, there was no record of further recording of their weight to show if these measures had been effective or ensure they had reached the healthy weight described in their care plan.
- We received mixed feedback about the quality of the food. Many people told us they were happy with the food provided. We received comments such as, "The food is good and there is plenty of it" and "The food is good, and they know my preferences." However, some people were not satisfied with the quality and choice on offer telling us, "I mostly don't like the food, everything is overcooked" and "The food won't give you your five a day as the vegetables are cooked to mush."

Failing to ensure people's nutritional and hydration needs were safely met was a breach of Regulation 14 (Meeting nutritional and hydration needs) 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.

● The service was not adhering to MCA guidelines. Capacity assessments were not always clear about which specific decision was being considered. We found examples of care plans where capacity assessments had not been carried out or had not been recorded.
● We found 16 examples where people had been assessed as lacking capacity to consent to their care and treatment, but the provider had not followed the correct legal process. There was no evidence of best interests meetings and no DoLS applications had been made to seek the legal authority to deprive people of their liberty.
● Where people had been assessed as having capacity to consent to their care and treatment there was no evidence that consent had been gained from the individual.

The failure to ensure the principles of the MCA were followed was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● There were a range of assessments of people's needs and choices yet these did not always result in effective care and treatment.
● Care plans did not contain sufficient detail about people's mental health needs. For example, a relative of one person told us their family member had significant mental health needs that impacted on their quality of life. The care plan did detail the person's diagnosis but there was no information on how this affected them or any guidance for staff on what to do if they observed changes or deterioration in the person's mental health.
● During our inspection we overheard someone shouting in distress during personal care. Staff confirmed that it was usual for this person to shout out in distress during personal care. We spoke with the person shortly afterwards and they did not have any lingering signs of distress and they told us they were fine, so we did not have any immediate concerns for their safety or wellbeing. However, their care plan did not contain any reference to these behaviours or any guidance for staff to help avoid these. The care notes of the day did not record the person's distress or anxiety that we overheard.

Adapting service, design, decoration to meet people's needs
● At the last inspection we identified that the service was not designed in line with best practice guidance around dementia friendly.

● The service had made improvements to the communal bathrooms and made them homelier and inviting. However, none of the bathrooms showed any sign of being used by the people receiving care. Many bathrooms were being used to store moving and handling equipment and there was no evidence that the water temperature checks had been taken which would indicate recent use.
● Areas of the service were still in need of decoration. People's bedroom walls had unsightly stains from previous maintenance work. Despite the improvements in the bathroom and some visual signage the environment did not meet best practice guidelines for people living with dementia.
● The service had installed pictorial signs on communal areas to indicate bathrooms, dining rooms and lounges. However, people's doors were identical and numbered without any visual representation to help people know which room was their own. Notice boards in the halls were not easily understandable for people with impaired cognition.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service was visited by the local GP to monitor people's health. Other professionals such as physiotherapists, speech and language therapists, tissue viability nurses and chiropodists also visited the service to provide additional support.
● The service did not always ensure people had access to the relevant professional. One relative told us they had to arrange for physiotherapy input for their family member as they were told the GP could not make a referral for this input.

Requires Improvement

Is the service caring?

Our findings

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

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

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

● People told us they felt well treated by the permanent staff. We received positive comments such as, "The regulars are all great, you can have a little laugh and joke with them" and "They are a great bunch and always cheerful." However, we observed examples of care that fell below the expected standard. During our inspection one person had not had a duvet cover on his duvet for four days, despite this having been requested from care staff on several occasions. The same person told us that they had not been supported to have a shave in the month they had been at the service.

● The high use of agency staff impacted on people's experience of the care they received. People told us, "There is too many agency staff" , "It's really important to have people you know otherwise you get depressed" and "The agency staff need supervision by a permanent member of staff as otherwise they don't know what they are doing."

● We were told by the local authority step-in team they had observed people lacked basic toiletries such as toothbrushes, toothpaste and shower gel. This was confirmed by a member of staff who told us they had bought people these items with their own money if people did not have relatives who would purchase these items for them.

Respecting and promoting people's privacy, dignity and independence

● Confidential information relating to people who used to live at the service and had moved on or passed away, was being stored in a communal 'family room' which was not locked or secured. The room was used for visiting family members so there was a risk that people using the service and visitors could access this personal information.

● During the inspection we observed that all communal bathrooms had a one-inch gap between the door and door frame, so people were unable to use the bathroom without the risk of being observed by people, staff or other visitors in the hallway. This impacted on people's privacy and dignity. We discussed this with the maintenance manager and they did not have an explanation of why the gap was present. They also confirmed that the service had established that the doors needed to be replaced to resolve the issue.

The failures to ensure people's dignity was maintained and to store their personal information securely 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 told us they felt able to express their views and staff would listen to them and resolve issues they had. We received comments such as, "I am able to say anything I want" and "I certainly tell them what I think." However, most people had not seen their care plan and did not know when it had been reviewed. We

asked the manager about people's participation in the review of their care plan but they were not able to show us that people had been involved.

Inadequate

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 Requires Improvement. At this inspection this key question has deteriorated 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

● We found there was a lack of evidence of individual involvement in care planning and review. Peoples care plans were generic and not person-centred. People's care plans were reviewed regularly by staff but there was no evidence that people receiving care or their relatives were involved in the review. One relative told us, "We have never seen [family member's] care plan so we have no idea if it is any good for them."

● Care plans contained conflicting information about people's ability to make choices about how to spend their time. One person's care plan stated they were 'unable to communicate their preferences and interests.' However, when we spoke with them it was clear they could communicate their wishes and preferences well and had very clear ideas about how they wanted to spend their time.

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

● There was a lack of meaningful activity on offer for people and the risk of social isolation had not been mitigated. People receiving care were mostly being nursed in bed and there was no evidence that they had been given the opportunity to get out of bed on a regular basis. Our observations throughout the inspection confirmed this was standard practice in the service.

● The service had started 'namaste' pampering sessions for people who could not get out of bed. Namaste care is a support programme designed to improve the quality of life of people living with dementia through meaningful sensory stimulation. However, we did not find these constituted sufficient stimulation and interaction for people and relatives of people receiving care shared these concerns. They told us, "We never see our [family member] out of bed. That would be very important to them to get out and see things, but we never see it happening." Another relative told us, "I would like to see [family member] out of bed but I don't think they do."

● Some people's activity plan stated that staff were to give them a copy of a daily newspaper every day to read. This did not constitute a meaningful plan of activity, and there was little evidence that it was happening as planned as it had not always been recorded.

End of life care and support

● There was lack of end of life care planning despite the service specialising in providing care for people with terminal conditions. The service had identified that staff needed training in this area but at the time of our inspection not all staff had received this training.

The failure to provide person centred care, ensure people's social needs were met and support people to make end of life plans 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

● There was a complaints process in place, but this was not always followed. We had been informed of a serious complaint made by a relative in January 2019 about the poor care and treatment of their family member. However, this was not included in the complaints log provided by the manager during the inspection and we did not see any evidence that the complaint had been investigated and any action taken.

● We were also told that someone had complained to the previous manager about not getting their medicines due to the recurring supply issues. The person had not been given any assurances that the matter would be resolved, and the issue persisted up to the time of our inspection.

The failure to investigate and respond to complaints was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had a communication care plan in place which detailed any support or aids they needed in order to engage fully in their surroundings.

● Easy read documentation was not readily available within the home for some people who may not know or think to ask for this. The service did not have information in pictorial formats for people who might benefit from this.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question had 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.

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

- The service had not been well managed. Quality audits supplied by the manager during the inspection did not identify all the issues we found with medicines, risk management, people receiving adequate support to eat and drink, adherence to the Mental Capacity Act 2005, person-centred care, respect and dignity and the management of complaints.
- Areas of concern that had been identified in the audits had not improved and in many cases had deteriorated. Lack of training for staff had been noted in the previous compliance audits and the previous CQC inspection report. However, we found this had not been resolved and staff still lacked adequate training to ensure they had the skills to meet the needs of the people receiving care.
- The issue of people's ability to reach their call bells had been raised with the provider through a complaint to the commission in July 2019. However, the service had not learned by this complaint as we found this problem had persisted to the time of our inspection and people were still at risk of being neglected.
- Persistent problems with the supply of medicines had been identified in the provider's internal audit carried out in April 2019. The audit confirmed that this had resulted in missed doses of medicines, but we did not find any record of the missed doses and the service had failed to resolve the problem with supply issues.
- Staff told us they were positive the manager was making improvements but as this was a very recent appointment we could not tell if improvements would be sustained.
- Since the inspection we discussed our concerns with the nominated individual and other managers within the organisation and they have provided an action plan of improvement.

The failure to assess, monitor and improve the quality and safety of the service effectively was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There had been several changes of management in recent months. The manager that was in post at the time of the last inspection in January 2019 left in July 2019 and the service was managed by a temporary manager until a permanent manager was recruited in September 2019. This person was suspended pending investigations into allegations of abuse and has since resigned. These changes in management had resulted in a lack of leadership within the service which in turn had contributed to low staff morale and the

deterioration in the standards of care we observed. One staff member told us, "There have been five managers here since I started so you never know who to go to."

● Staff were positive that the manager now in place was making improvements to the service. We received comments such as, "[Manager] is really supportive and understanding" and "I think the new manager is already making things better. I think we are on the right track now."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● There was lack of meaningful engagement with people using the service and their relatives. The service conducted annual satisfaction surveys which found there were areas where people were not satisfied with aspects of the service. There was no evidence that the satisfaction survey had resulted in any improvements within the service.

● Relatives told us they had difficulty speaking to the manager or a senior member of staff when they wanted to discuss their family member. On relative told us, "We tried to get through to someone at first but in the end, we gave up trying as no one came back to us." Another relative told us, "Nobody told us the manager had changed. It would be good if they could have told us who to contact if we wanted to discuss anything."

● The previous manager had convened a relative's meeting in August 2019 to give relatives the opportunity to meet the manager and discuss any concerns they had. This meeting was attended by only three relatives of people receiving care and due to the changes in manager we could not tell if this engagement was going to be developed further.

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 manager has provided us with the relevant notifications of serious incidents and concerns that have been identified during our inspection, by the current manager or the local authority. The manager informed people and their relatives of the allegations of abuse and the ongoing police investigation.

Working in partnership with others

● The service worked .in partnership with a range of local health professionals such as the GP and a local hospice to ensure people's end of life health needs were being met. However, the partnership working did not always achieve good outcomes for people. One relative told us they had to arrange for physiotherapy input for their family member as the GP told them they could not do this. The lack of end of life planning at the service indicated that the partnership with Trinity Hospice was also not effective.

● Quality audits showed an ongoing issue with the supply of medicines that was attributed to the service provided by the dispensing pharmacy. There was no record of any steps taken to address the issue with the pharmacy and the issue persisted to the time of our inspection.