Sudera Care Associates Limited

Ridgeway Nursing Home

Inspection report

Crich Lane
Ridgeway
Belper
Derbyshire
DE56 2JH

Tel: 01773853500

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ridgeway Nursing Home is a care home in Belper, Derbyshire, providing personal and nursing care to 21 people aged 65 and over at the time of the inspection. The service is registered to support up to 37 people.

People's experience of using this service and what we found
Safeguarding procedures were not fully embedded, and the provider did not always respond to concerns of abuse. Information about risks to people's safety were not always clear and were not shared with staff. Safe recruitment practices were not in place when agency staff were employed.

The registered manager did not operate governance systems effectively and the provider had failed to identify this. The system in place for the provider to maintain their oversight did not check the information provided and at times, information was misleading and incorrect. Openness and transparency continued to be lacking and legal requirements were not always met.

People were not supported to have maximum choice and control of their lives and staff were not guided to 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. The provider did not always ensure they complied with the law for depriving people of their liberty when they lacked the ability to make this decision. The provider had not ensured staff were always provided with the training they needed to carry out their role effectively.

People's privacy, dignity and confidentiality were not always respected. Staff offered people choices during day to day interactions, but documentation did not demonstrate people, or their relatives were involved in decisions about their care.

The provider had failed to ensure people were empowered to express their wishes for the end of their lives if they chose to. The provider did not always ensure people's communication needs were met.

Although infection prevention and control procedures had improved since the last inspection, further improvement was still required. Medicines were safely managed. People were supported to eat and drink enough. Staff were kind, caring, patient and compassionate towards people. Staff knew people well and developed close relationships. People were supported to take part in activities they enjoyed.

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 inadequate (published 3 March 2021). Multiple breaches of regulations were found.

This service has been in Special Measures since 3 March 2021. During this inspection we found that not

enough improvements had been made. Therefore, this service remains in Special Measures.

Why we inspected
This was a planned inspection based on the previous rating.

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.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety, safeguarding people from abuse, staff training, governance, recruitment and meeting legal requirements at this inspection. Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we 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 remains 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?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always 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.

Ridgeway 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This 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
Ridgeway 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 had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was announced to the provider and registered manager by email, the inspection team arrived at the home simultaneously as the email arrived. We did this so we could reassure the provider of the COVID-19 tests and training completed by the inspection team and give the provider the opportunity to send some information by email if they chose to.

What we did before inspection
We reviewed information we had received about the service since the last inspection, including information

the provider had been required to send to us. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

During the inspection
We spoke with four people who used the service and 12 relatives about their experience of the care provided. We spoke with 18 members of staff including the provider, registered manager, deputy manager, independent consultant and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at nine staff files in relation to recruitment and staff supervision (including agency staff). A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people were protected from abuse and improper treatment . This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 13.

- People were not always protected from abuse and improper treatment. The provider did not operate systems effectively to ensure they were aware of and investigated all safeguarding concerns.
- Not all staff were up to date with safeguarding training. There were six staff shown on the rota to be working who had not completed training in safeguarding.
- Although staff recognised and documented incidents that could constitute abuse, the management team did not always review the documentation in a timely manner. Some incidents had been referred to the safeguarding team, however, we identified a further six incidents since our last inspection of physical abuse, sexualised behaviour and unexplained bruising that had not. This meant that there was no investigation into the potential abuse and therefore no information about how to prevent the same thing happening again.

The provider had not ensured people were protected from abuse and improper treatment. This was a continued breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had not done all that was reasonably practicable to mitigate risk of avoidable harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management

- Assessment of risk to people's safety was not clear and staff did not always have access to this information.
- Personal Emergency Evacuation Procedures (PEEPs) were now in place; however, they were kept in a locked office and only the registered manager, administration assistant or nurse on duty had the key.

Therefore, in an emergency situation staff might not have been able to get these quickly. Some of the PEEPs contained unclear, unsafe or contradictory information. This could create confusion for external first responders, such as the fire brigade in an emergency.

● People's care plans were also stored in the locked office, this meant staff were not able to read the risk assessments that were stored within care plans. This meant new staff and agency staff were not provided with consistent guidance about how to keep people safe.

● Risk assessments were not always clear. For example, assessments of falls risk were completed on up to three different forms, each containing different information and stored in different parts of the care plans, therefore it was not easy for staff to read and understand how support people safely.

● Risk assessments for COVID-19 had been completed since the last inspection, but every assessment was identical, this meant people's individual circumstances had not been considered.

Learning lessons when things go wrong

● When things had gone wrong, they were not always investigated in a timely manner. Although a system had been implemented since the last inspection this was not being used effectively.

● The registered manager had failed to ensure all relevant documented incidents were included in the monthly analysis of accidents and incidents. For example, the January analysis only included one incident and we found a further five documented incidents.

● Seven of the 15 recorded incidents since the last inspection had not been reviewed by the registered manager or member of the management team. Records detailing when people displayed behaviours that challenged were not reviewed. This meant opportunities to learn from adverse incidents may have been missed.

● Where an analysis had been completed, there was no outcome reached and no record of lessons learned to prevent the same thing happening again.

Preventing and controlling infection

● People were not always protected from the risk of infection. The provider did not always work within current national guidance in relation to infection prevention and control during the COVID-19 pandemic.

● Although some improvements had been made since the last inspection in regard to COVID-19 safety, further improvement was still required. We saw two occasions when the registered manager was not wearing PPE. The registered manager and the deputy manager were not meeting government COVID-19 guidelines with their clothing.

● The provider was unable to demonstrate they had checked all agency staff had completed rapid COVID-19 testing before entering the building. Clear and accurate records of this testing for agency staff were not kept.

● Government guidelines for COVID-19 at the time of the inspection recommended care homes use the same regular agency staff where possible to minimise the number of staff going into different care homes. We found a large number of agency staff had worked at Ridgeway Nursing Home. Therefore, the provider could not demonstrate they had made efforts to ensure they used regular agency staff as much as possible.

● Failure to implement effective infection control procedures could have a negative impact upon people's health.

The provider had not done all that was reasonably possible to mitigate, minimise and manage the risk of avoidable harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the Registered Manager contacted us to tell us that copies of PEEPs were now stored in three separate areas of the home and were now more easily accessible to staff. They also told us that staff

now had access to the key to the locked office where care plans were stored. However, there was no reassurance that staff now had the time to read care plans or that risk assessments had been reviewed to ensure they were clear.

Staffing and recruitment

● Safe recruitment practices were not always in place. When agency staff were employed, the provider had not always reviewed their background checks to ensure they were adequately trained and were safe to work with vulnerable people. For 20 of the agency staff who had worked at Ridgeway Nursing Home throughout April 2021, the provider had not checked their training or criminal records history.

The provider had failed to ensure there was always safe recruitment procedures in place. This was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Clear and accurate records of staffing were not maintained. For example, some rotas did not include staff names and some only included the staff first name. This meant the provider was not able to demonstrate who had been in the building at all times.

● Permanent staff were safely recruited. There were enough staff on duty to spend time with people and meet people's needs in a safe and timely way.

Using medicines safely

● People continued to receive their medicines safely. Accurate records of medicine receipt, administration and disposal were kept. Medicines were stored safely and with regard to nationally recognised guidelines.

● For people who required medicines as and when required, clear protocols were in place to ensure staff understood why this medicine was required, how it should be administered and any potential side effects.

Requires Improvement

Is the service effective?

Our findings

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

At the most recent inspection this key question was not looked at. (At the previous inspection in December 2019 this key question was rated as good). At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider had not ensured staff were supported to undertake training to enable them to fulfil the requirements of their role. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18. The staff training was discussed in the Safe domain of the last report but is included in the Effective domain in this report.

Staff support: induction, training, skills and experience

- The provider had not ensured staff were provided with training to make sure they had the necessary skills to carry out their role. Clear and accurate records of staff training were not kept.
- Although some training had been implemented since the last inspection, there was still staff working there with no record of training in safeguarding, infection control, moving and handling, fire safety or food hygiene. Some staff told us they had not done any training at all whilst working at Ridgeway Nursing Home.
- Not all staff had been offered training to guide them to support people living with dementia, at the end of their lives or for people who displayed behaviours that could challenge. This was despite there being numerous people there living there who required this support.
- This lack of training had a negative impact on staff practice. For example, staff lacked training in managing behaviours and we found they didn't know they weren't always responding to, or recording, behaviours that challenged in the most effective way.
- There was no record of new staff or agency receiving an induction or having their competency in their role assessed. This meant the provider could not demonstrate they had assessed staff as safe to carry out their role.
- Staff told us they did not feel they did enough training to do their job effectively. One staff member said, "We don't do training as such, no-one assesses our competency, there's no challenging behaviour training."

The provider had not ensured staff were supported to undertake training to enable them to fulfil the requirements of their role. This was a continued breach of regulation 18 (Staffing) 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; 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.

● Some people were unlawfully deprived of their liberty. There were 10 people living in the home, (who were not able to leave the home unsupervised due to locked doors) who lacked the capacity to make their own decisions and the provider had no record of applying for Deprivation of Liberty Safeguards.
● Staff were not supported to know who was subject to a DoLS and who wasn't because staff did not have access to care plans and the information that was in care plans wasn't always clear.

Some people were unlawfully deprived of their liberty. This was a continued breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was not always operating the service in line with the MCA. Some people lacked capacity to make important decisions. We found consent to care and treatment and best interest decisions had not always been obtained in line with legislation and guidance of MCA and DoLS to ensure people's rights were protected.
● Some mental capacity assessments had been completed, and these were specific to a particular decision. However, there were some important decisions, such as consenting to COVID-19 testing and the need to isolate during the pandemic that had no record of being made involving people or that a decision had been made in their best interests.
● Some people's relatives had been granted Lasting Power of Attorney (LPA). This meant they had a legal right to make decisions on behalf of their relation. Information about LPA was not made clear in people's care plans. We found one LPA certificate was contained at the very back of the large care plan and had not been referred to in the person's mental capacity assessments, or in any other documentation.
● Staff knew people well on a personal level and assessed their needs and choices whilst supporting them. However, staff were not guided to understand people's holistic needs and preferences within the care plan records because staff did not have access to these. This placed people at risk of inconsistent support.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
● The provider did not always ensure people were supported to live healthier lives. Although we saw improvements had been made in proactive healthcare referrals since the last inspection, the provider was not guiding staff to monitor people's oral care and there was not always records to demonstrate people's oral care needs were assessed or monitored. This lack of information placed people at risk of receiving poor oral care.

● People were supported to eat and drink enough and their personal choices were catered for.

Staff working with other agencies to provide consistent, effective, timely care
● The sharing of information with other agencies remained inconsistent. For example, the provider had received guidance from the safeguarding authority about what constituted abuse but had not followed their instructions.

Adapting service, design, decoration to meet people's needs
● The home and particularly people's bedrooms were not decorated to a consistent standard and some areas felt impersonal. For example, some people's bedrooms were decorated in way that felt homely and reflected their preferences, others were empty and sparse. There was no evidence that people had chosen to keep their bedrooms in this way.
● People chose where in the home they spent the majority of their time and there was a choice of communal areas. The garden had been designed so people could enjoy the outside space if they wanted to.

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 most recent inspection this key question was not looked at. (At the previous inspection in December 2019 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.

Respecting and promoting people's privacy, dignity and independence

- People's privacy, dignity and confidentiality were not always respected.
- We observed a staff member making and receiving phone calls with healthcare professionals discussing people's health. This took place in the communal lounge where other people, staff and visiting healthcare professionals could hear. No effort had been made to use any of the many available private spaces within the home to complete this.
- Staff did not always promote people's dignity when completing documentation. For example, we reviewed records where staff had used derogatory language to describe a person's behaviour.
- Visits with friends or relatives took place in a vacant bedroom. No effort had been made to change the décor or the furniture to make this a homely and inviting place for people to enjoy visits. After the inspection the registered manager informed us, he had taken our feedback on board and there were plans to make the visiting room more welcoming.
- People who wished to remain alone in their bedroom throughout the day were supported to do this. Those who wanted to go out for a walk with staff were enabled to do so.

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

- The provider did not ensure people had all the support they would need to make and express as many decisions about their own care as possible.
- People were not supported to have access to independent advocacy. There was no information about advocacy available to people in the home. An independent advocate is a person who assists and supports people to express their views and ensures a person's views are known.

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

- People were treated with kindness and compassion by staff who were patient and calm during all the interactions we saw.
- People's relatives spoke highly of the staff and felt their relations were treated with kindness. One relative said, "I don't have any issues at all. The staff are lovely." Another relative said, "The staff are ever so nice." A different relative said, "My goodness I think it's a fabulous place."
- Care plans contained information about people's needs and preferences relating to their spiritual beliefs, however, as staff were not always able to read care plans and as care plans were so overloaded with historic information, it meant people may receive inconsistent support.

Requires Improvement

Is the service responsive?

Our findings

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

At the most recent inspection this key question was not looked at. (At the previous inspection in December 2019 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.

End of life care and support

● People's personal wishes for how they would like to be supported at the end of their lives were not explored or recorded.

● The provider had ensured there was information about whether people would be resuscitated or admitted to hospital if they became acutely unwell. But they had failed to explore people's advance wishes or if they would like to discuss this. This meant there was a risk people might not receive the care they would like if there were to approach the end of their lives.

● Staff had not received training in end of life care and had supported people when they reached the end of their lives. After the inspection the registered manager contacted us to say he had arranged for end of life care training for staff.

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.

● The provider had not taken steps to comply with the AIS. Documentation was all provided in the same format. Information on the walls, such as food menus were in small text and pictorial images had not been used to assist people living with dementia or with sensory loss to be able to understand this.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 and their relatives were not included or involved in care plan reviews. These were completed by a nurse and did not include communication with people or relatives. Relatives told us they felt staff knew their relations well, but they didn't feel they played an active role in their care. One relative said, "There's no regular contact but they let us know if something happens."

● There was information stored within care plans about people's life histories and personal preferences. However, staff told us they didn't get to read the care plans so made attempts to get to know people without being provided with this information.

● People were not always supported to maintain personal relationships. During this inspection, home visiting had recently started again after this had been cancelled due to a case of COVID-19. Two people's

relatives told us they had not been informed they could visit again. This did not promote people's independence or well-being. One relative said, "They don't ring me." Other people were supported to have visitors, however, relatives told us this relied on them phoning the home to request this rather than the home informing all relatives about visiting procedures.

● People could take part in person-centred activities if they wished to. There was an activities co-ordinator who supported people and arranged visits with relatives. During the inspection we saw the activities co-ordinator and care staff engaging people in meaningful activities. However, one relative told us they felt their relation did not receive enough stimulation.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy, and this was easily accessible to staff. There were no records of any complaints having been received since our last inspection.

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 inadequate. At this inspection this key question has remained the same. 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.

At our last inspection the provider had not implemented effective systems to assess and monitor the quality of care, this included a lack of overall scrutiny at board level. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

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

- Systems for identifying and managing organisational risk were not used effectively. The registered manager and provider did not always understand or meet legal requirements.
- Since the last inspection, the governance system had been reviewed and updated. However, this was not used effectively by the registered manager. For example, the safeguarding and DoLS section of the manager audit said, 'see safeguarding/ DoLS file'. The safeguarding and DoLS files did not include an audit, tracker or analysis. The registered manager's audit had failed to identify the lack of safeguarding and DoLS applications or any of the other breaches of regulations identified at this inspection.
- The provider had a system to retain over all scrutiny of the service. However, this was also not operated effectively. We identified two entries where the registered manager had included false and misleading information.
- There was no oversight or analysis of safeguarding referrals, staff training, people's weights and skin integrity, people's daily logs or records of behaviours that challenged, this led to the provider failing to recognise some safeguarding concerns.
- Care plans were audited by an external consultant. However, only three care plans had been audited since our last inspection and the recommendations recorded had not been completed.

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

- Staff had no access to the information in people's care plans. When asked why, one senior staff member said, "There are things in there staff are not allowed to see." The registered manager said this was because some records had been going missing, however, there was no investigation of this and no documentation to explain how this was thought to be the safest option.
- People and staff were not always given the information they needed. For example, the registered manager

was completing staff meetings, but minutes of these were not routinely taken and were not shared with staff. Therefore, staff who were not present at the meeting did not know what had been discussed. One staff member said, "If you miss a team meeting there's no notes, or they can be weeks down the line with limited information."

● One record, completed by a staff member, contained derogatory language describing another staff member's ethnicity. The registered manager had not reviewed this and had not addressed this with the staff member who completed it. Staff had not completed training to support them to recognise and promote equality and diversity.

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

● One relative and some staff continued to say the service was not well-led. One relative said, "Our only concern is about the manager. I don't think he is that supportive, he blames others for his failings."

● Staff told us they did not feel listened to, valued or respected. One staff member said, "The manager is [….] unapproachable, I would not feel comfortable taking concerns to him." A different staff member said they find it hard to have a work life balance because they don't find out their shifts with enough notice and are expected to work with less than 24 hours' notice.

The provider did not operate systems effectively to assess and monitor the quality of care. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other relatives did not mention contact with the registered manager but did praise the staff.

At our last inspection the provider had not acted in an open and transparent way. This was a breach of Regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 20.

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; Working in partnership with others

● The registered manager continued to lack openness and transparency. For example, the registered manager assured us and the provider that written apologies had been sent out to all relatives of people who had experienced abuse that was identified at the last inspection. The registered manager was unable to provide evidence of this to us. When asked, the relatives we spoke with told us they had not received this and the only written communication they received was an email asking for positive feedback.

The provider had not always acted in an open and transparent way. This was a continued breach of Regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had not submitted notifications of serious injuries or abuse CQC. This was a breach of Regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● The provider continued to fail to submit notifications of abuse or alleged abuse. When asked why this was, the registered manager told us he was not aware he was supposed to do this. This was mentioned in the last inspection report.

The provider had not submitted notifications of serious injuries or abuse to CQC. This was a continued breach of Regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009

At our last inspection the provider had not submitted notifications of people's deaths to CQC. This was a breach of Regulation 16 (Notification of Death of Service User) of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 16.

● The registered manager had assured us and the provider that notifications had been retrospectively submitted for all people who had died at the home. Although some retrospective notifications had been submitted, a significant number had not.

The provider had not submitted notifications of people's deaths to CQC. This was a continued breach of Regulation 16 (Notification of Death of Service User) of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure there was always safe recruitment procedures in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not always acted in an open and transparent way.