Cole Valley Care Limited

Cole Valley

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

Summary of findings

Overall summary

About the service: Cole Valley is a residential nursing home that provides accommodation and nursing care to up to 45 people. At the time of the inspection there were 24 older people living at the service, many of whom were living with dementia.

People's experience of using this service:
•□People were not protected from the risk of serious harm due to inadequate risk management processes within the service. People were also not sufficiently protected from the risk of abuse and mistreatment.
•□People were exposed to the risk of harm due to unsafe recruitment practices. Insufficient pre-employment checks and risk assessment meant staff members who were unsuitable to work with vulnerable people could be recruited.
•□People's rights were not upheld with the effective use of the Mental Capacity Act 2005 (MCA). People were not always fully enabled to make choices and to fully participate in the development of their care and support plans.
•□People were not always supported in a caring environment where their privacy, dignity and independence was respected and promoted.
•□The provider had not ensured complaints were managed effectively. They had also not ensure people's views were proactively sought and used to improve the safety and quality of care provided.
•□The provider had failed to ensure that sufficient and effective management, quality assurance and monitoring systems in place. As a result, they were not aware of the widespread concerns we found during our inspection. They had not ensured the quality and safety of care was sufficiently monitored and that appropriate action was taken to protect people from the ongoing risk of harm.

The overall rating for this service is 'Inadequate' and the service therefore 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.
Rating at last inspection: At the last inspection completed on 20 and 21 August 2018 the service was rated as inadequate and was entered into special measures. We published this report on 19 September 2018.

Why we inspected: This inspection was a scheduled inspection based on the previous rating. Prior to the inspection we were notified about a serious incident in which a person using the service died following an accident within the service. We looked at risks associated with this. Further information is in the full report.

Enforcement: 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 keep this service under review and will publish details of our regulatory response once this has been concluded.

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

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?

Inadequate

The service was not 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.

Cole Valley

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Prior to the inspection CQC was notified about a serious incident where someone had died following an accident at the service. The information shared with CQC about the incident indicated potential concerns about how the risk of falls and safe use of equipment was managed. As a result of these concerns we looked at how the provider was managing risks and protecting people from potential harm caused through accidents and incidents.

Inspection team:
The inspection was completed by a inspector, an assistant inspector, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a qualified nurse with experience of working with older people.

Service and service type:
Cole Valley 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. Cole Valley accommodates up to 45 people in one adapted building.

The service requires a manager who is 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. At the time of this inspection the registered manager was no longer employed by the service and had failed to submit an application to cancel their registration. A new manager was in post although their employment with the service finished shortly after the inspection took place.

Notice of inspection:
The inspection was unannounced.

What we did:
As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with four people who used the service and three relatives. Many people who lived in the service were unable to share their views regarding the care they received. To help us understand the experiences of these people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out observations across the service regarding the quality of care people received. We spoke with the provider, the registered manager and 11 staff members including kitchen staff, domestic staff, nurses, care assistants and activities coordinators. We reviewed records relating to people's medicines, 18 people's care records and records relating to the management of the service; including staff recruitment records, complaints and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our last inspection completed in August 2018 we rated the service as 'inadequate' for this key question. We identified breaches of regulation around safeguarding people, staffing levels and safe care and treatment. At this inspection we found insufficient improvement had been made and the service remained 'inadequate'. The provider had still not met legal requirements around safeguarding, safe care and safe recruitment practices.

Systems and processes to safeguard people from the risk of abuse

- We found multiple allegations of abuse had been raised by relatives, staff members and an anonymous whistleblower over a period of several months. These allegations stated there was inappropriate care and treatment of people by staff which put them at risk of harm. It was also stated people were at risk of harm due to the behaviours and action of other people who lived at the service. We found insufficient action had been taken by the manager and provider to address these risks.
- Concerns had not been reported to the local safeguarding authority, appropriate investigations had not been completed and plans had not been put in place to protect people from the risk of further harm by the provider.

The provider's failure to ensure robust safeguarding systems were in place was a breach of Regulation 13 of the Health and Social Care Act 2008 (Reguated Activities) Regulations 2014. Safeguarding people who use services from abuse.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- While some people and relatives told us they were happy with the safety of people and the management of risk in the service, this view was not shared by everyone we spoke with.
- One relative told us, "I trust them implicitly with my [relative]. I don't feel worried about his treatment at all". Another relative told us how they felt risks relating to their family member's skin integrity and falls were well managed. They told us, "He has a hospital bed and an air mattress. They put a crash mat on the floor".
- Other people shared concerns about the way certain risks to them were managed and most people told us their call bell was not accessible to allow them to summon staff. This practice exposed them to the risk of harm. One person told us, "I find the buzzer difficult to use because it's on the left hand side and I'm right handed. When I call them they [staff] take a long time to come." Another person told us, "I use the buzzer or I shout to get help. They [staff] don't come to me as quickly as I would like them to." We saw some people were in their rooms, unable to move without support, unable to shout for help and without their call bells in reach. We raised this concern with the manager and saw call bells were accessible to these people by the end of our inspection.
- We found multiple people within the service required a texture modified diet to reduce the risk of issues such as choking and aspirating food onto the lungs. Records and care plans contained insufficient or

contradictory information about these people's needs and the texture of diet they required. Staff we spoke with did not understand people's needs and we saw the food provided to people did not always match what was outlined to us by either staff or records. The provider had failed to ensure people were protected from the risk of choking or aspiration by providing them with appropriately prepared foods.

•□We found some people were presenting behaviours that may put other people who lived at the service and staff at risk of harm. The provider had taken insufficient action to safely manage the associated risks to people and staff. For example; one person had entered the bedroom of another and had attempted to take their personal possessions and hit them. Action had not been taken to protect people following prior incidents to protect people from further harm and no action was taken following this incident. As a result people were exposed to the ongoing risk of harm.

•□The provider had inadequate systems in place to ensure accidents and incidents were reported to management. We found care records outlined accidents that had occurred, and the management team were unaware of them. The manager told us no action had been taken to minimise the risk of similar incidents arising and preventing further harm to people.

•□Even when we found the provider and management team were aware of accidents and incidents, they had still not taken sufficient action to keep people safe. A coroner had made clear recommendations to the provider as to how to protect people several weeks prior to our inspection. At the time of our inspection the provider had not acted on the reccomendations.

The provider's failure to ensure risks to people were appropriately managed and mitigated against was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Staffing and recruitment

•□People and their relatives told us there were sufficient numbers of staff available to support people safely and this reflected what we saw during our inspection. We did see staff deployment could be improved to ensure people were not required to wait for support by staff.

•□The provider had failed to ensure appropriate pre-employment checks were completed for all staff members prior to them starting work within the service. We found some staff employment histories had been obtained in full, but this was not consistently done. We identified staff files where there were gaps or descrepencies in information given, which had not been explored further by the provider. The provider had also failed to ensure they were aware of the reason for people leaving prior positions in care as required by law.

•□Where staff members had information disclosed through their Disclosure and Barring Service check (DBS) that required further exploration and risk assessment, the provider had failed to do this. As a result, people were exposed to the potential risk of unsuitable staff members working without appropriate supervision and risk measures in place.

•□We found reference checks completed were not always robust. Prior employers who were care providers were not always approached and the source of references were not always appropriately verified.

The provider's failure to ensure that appropriate pre-employment checks were completed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed

Preventing and controlling infection

•□People told us they felt the service was kept clean and care practices were hygienic. One person said, "It's always clean here, we've got some nice cleaners". Relatives we spoke with agreed with this view.

•□Domestic staff told us about improvements made since our last inspection. We saw general cleaning

within the service was completed to a good standard.
•□We found some improvements could be made. For example; we saw staining and some soiling to walls in toilets and some deep cleaning was required.

Using medicines safely
•□People told us they were happy with the support they received with their medication. One person told us, "I take medication. They get it for me but I take it myself. It's done correctly."
•□We found improvements had been made to medicines management systems. We found medicines were stored securely and safely. We also found the amount of medicines held in the service for each person checked matched the amounts outlined on their medicines administration records (MAR).
•□We saw medicines being administered safely and a records of administration were accurate.

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

At our last inspection in August 2018 the service was rated as 'requires improvement' for this key question. We identified breaches of regulation around the need for consent and training. At this inspection we found while some improvements had been made to staff training, the service had deteriorated overall and this key question was now 'inadequate'. The provider continued to fail to meet the legal requirements around the need for consent.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
- We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- While some staff we spoke with demonstrated an understanding of the MCA, this was not consistent. Some staff members, including nursing and management staff, did not demonstrate a sufficient understanding of the requirements of the law.
- We found decisions were being made on behalf of people who lacked capacity without the requirements of the MCA being followed. For example; one person was being hoisted without their consent and as a result hit staff members. While the manager told us they thought the person lacked capacity, they had not completed an assessment of their capacity as required by the MCA. As the manager had not confirmed the status of the person's capacity and had not considered how a decision may need to be made in the person's best interests, the use of the hoist without consent could be unlawful.
- We found further examples of decisions being made on behalf of people without consideration of the MCA, including the use of sensor mats, crash mats, covert medicines, bed rails and changes to people's diet.

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

- We found DoLS applications had been made to deprive people of their liberty as being required by law.

However, the manager lacked understanding of which applications had been granted and when someone was being deprived of their liberty. Many applications had been rejected by the local authority as they had not clearly identified the level of deprivation being used within the service. As a result, some people were being deprived of their liberty and an appropriate application was not in place.

The provider's failure to ensure people were only deprived of their liberty with appropriate authorisations in place was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people who use services from abuse.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The provider had failed to ensure people's needs were appropriately assessed and understood. For example, we found people's nutritional needs in relation to texture modified diets were not assessed and were not understood by staff or management. Due to the concerns we identified during our inspection, the manager was required to make urgent contact with Speech and Language Therapists (SaLT) to establish how the provider should protect people. We also found people's needs in other areas had not been sufficiently assessed and understood; this included wounds, skin integrity and the use of wheelchairs.
• The provider's failure to ensure people's needs were appropriately assessed and understood in order to protect them from harm was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Staff support: induction, training, skills and experience
• People told us they felt most staff members had the skills to support them safely.
• Staff told us improvements had been made to the training they received since our last inspection and they now had more frequent training. This reflected the training records we saw.
• We found training had improved although staff members continued to lack the skills they required in certain areas to support people effectively. For example; staff members lacked the knowledge they required in areas such as texture modified diets and the MCA.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• We found some inconsistencies around how well peole were supported to live healthier lives. While some people had gained access to appropriate healthcare professionals others had not. For example, one person told us they had seen the doctor regularly and had an appointment with the chiropodist although they told us, "I need to see the optician and the dentist". A relative however said, "[My family member] has seen an optician and a dentist".
• We found the provider gave access to healthcare professionals but did not ensure this was done proactively. For example; following concerns we raised about some people's dental hygiene at our last inspection the provider had arranged for these people to see a dentist. The provider had not considered if others in the service may need to see a dentist. As a result, at this inspection we identified more people with poor dental hygiene and the provider could not tell us when they had last seen a dentist.
• We found while people saw the doctor people's needs were not always effectively monitored and advice was not sought when needed. We saw advice had been given by the Tissue Viability Nurses (TVN) which had not followed, and we saw health concerns such as pressure ulcers, skin tears, swalling issues, pain and weight gain had not been sufficiently identified and addressed by the provider. Contact with appropriate healthcare professionals had not been made.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they were mostly happy with the food and drink they received. One person told us, "The

food here is very good". Another person told us, "I've tasted worse and I've tasted better food than we get here. This morning for my breakfast I had porridge, tea and cheese on toast." A relative told us, "I've had some dinners here and breakfast. The food is lovely."

•□We found the quality of food provided was good and most people were not losing unnecessary weight.

•□We did find concerns with people's needs in relation to any specific dietary needs being met; in particular with texture modified diets. We also found where people were gaining weight, this was not always identified and appropriate action had not been taken.

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

•□People told us they were happy with the design and layout of the building and felt it met their needs. One person told us, "The building is very nice. There's plenty of room. There is a garden but I don't go into it. If I asked them to take me into they garden they would do". A relative told us, "I did suggest that they could make the garden nice with a few flowers. They have put pots in the garden. It's nice to sit there with the flowers."

•□We found improvements could be made to ensure the building met with best practice in respect of dementia friendly environments. For example; dementia friendly signage was limited and could assist with people being able to move around the service more independently without 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

People did not always feel well-supported, cared for or treated with dignity and respect.

At the last inspection completed in August 2018 we rated this key question as 'requires improvement'. At this inspection we found sufficient improvement had not been made and the service remained 'requires improvement'.

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

- Some people told us staff were kind to them while other people felt they were made to feel unimportant, marginalised and isolated. One person told us, "The staff are good. They are kind to me. No-one has ever been rude to me." Another person told us, "Sometimes we go a long time without seeing anyone. It can sometimes be two hours". A third person told us, "Down here I'm cut off from everyone else, it's annoying".
- We saw some interactions between people and staff members were warm and positive. However, we saw other interactions and care provision that was not caring. We saw people in their rooms unable to move with call bells, TV remotes and drinks out of their reach. We found one person who was unable to clearly articulate their needs. They told us they were in pain and staff had failed to identify this and provide support.

- We found the provider and management team failed to foster a culture that supported a caring environment. For example; we found insufficient leadership and management arrangements focused on monitoring the quality of care provided. We identified concerns had been raised around how people were treated by specific staff members and other people in the service. The provider had failed to ensure these concerns were sufficiently investigated and that people were supported to live in their home free from any potential mistreatment.

Respecting and promoting people's privacy, dignity and independence

- People gave us mixed views of how well care staff respected and promoted their privacy, dignity and independence. One person told us, "My privacy is mostly respected. My door is always open. I like it that way." They also told us, "When the staff are washing me, they close the door and draw the curtains". Another told us, "The staff don't always ask to come into my room. The door is always open."
- We saw some good examples of where people were supported with things such as personal care in a discreet way and their independence promoted. However, we saw other examples of where people were not supported in a dignified way. For example, we saw several occasions where someone was lifted using a hoist and their dignity was compromised. The person was not sufficiently covered and their underwear was on view to other people and visitors in the service. Staff supporting the person did not recognise the person's dignity was compromised.

The provider's failure to ensure people were treated with dignity and respect with their independence promoted was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations Dignity and respect

Supporting people to express their views and be involved in making decisions about their care
• Several of the people we spoke with told us they didn't make decisions about their care and this was reflected in what we saw during our inspection.
• We saw some good examples of people being given choice and this being respected. For example; where people expressed they did not want the food made available to them, alternatives were sought and given. However, this practice was not consistent across the service. One person told us they had wanted to stay in their room but had been told they had to go to the lounge to play bingo as CQC were in the service.

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

At the last inspection completed in August 2018 we rated this key question as 'inadequate'. We identified breaches of regulation around person-centred care. At this inspection we found insufficient improvement had been made, and the service remained inadequate. Legal requirements around person-centred care continued to be unmet.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- Most people and relatives were unaware of their or their loved ones care plan which should set out their care and support needs. One person told us, "I'm not aware of a care plan. I don't know about that." A relative told us, "I can't remember anything about [person's name's] care plan".
- People had mixed views about the level of involvement they had in decisions about their care, this view shared by relatives. Some people said they did not get involved in decisions about their care. We found where people did not have the ability to clearly communicate their needs, the provider had not ensured all possible steps were taken to involve them in developing their care plans as far as reasonably possible. Some people told us the care delivered met their needs while others did not. One person told us, "I would like them [staff] to do more for me but they can't be with me all the time".
- We found people's care needs were not always assessed, understood and clearly documented in their care plans. For example, we found people's needs around their nutrition, mobility, pain management and skin integrity were not understood by staff. The lack of clarity in care plans contributed to people's needs not always being met.
- Care plans around people's advance wishes for end of life care were basic and lacked detail, for example who they wanted present in their final days and hours.
- We received mixed views about activities within the service. One person told us, "It's a bit of a dump here. I would like to be able to come and go as I please. I would like to have a pet. I do go into the garden sometimes." They also told us, "We don't do anything". Another person told us, "I join in with the games sometimes". A relative told us, "They do activities here like karaoke and they play games. They also have Christmas parties and they make Easter bonnets."
- Despite some improvement in activity provision since our last inspection, there was still no clear, planned activities schedule that reflected people's expressed personal interests and wishes.

The provider's failure to ensure that people's needs and preferences were fully understood and met was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centered care.

Improving care quality in response to complaints or concerns

- People we spoke with told us they had not raised a formal complaint. One person said, "I've not made a

complaint but if I did have a complaint I would speak to the manager".

• We found systems were in place to record and respond to any complaints that were made but these had not always been dealt with effectively.

• We saw one complaint had been made by a relative about their family member being given food items by staff that put them at risk of choking. Despite an apology to the complainant, the complaint handler had not recognised or acknowledged the seriousness of the complaint and the level of risk the person had been exposed to. This showed the complaint investigations and action taken in response was inadequate and had not protected the person from the risk of further harm.

• The manager was not aware of the Accessible Information Standards they are required to comply with to ensure that information, including the complaints policy was made available in formats accessible to all.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection completed in August 2018 we rated this key question as 'inadequate'. We identified breaches of regulation around effective management and governance in addition to a failure to submit statutory notifications to CQC. At this inspection we found sufficient improvement had not been made and the service remained 'inadequate'. The provider continued to fail to meet legal requirements around effective management and governance in addition to a failure to submit statutory notifications.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider had not developed systems to monitor the care people received to ensure it was person-centred and met their needs. As a result people were exposed to the immediate risk of serious harm.
- We found multiple examples of where people's needs were not being met, these had not been identified by the provider or management team. For example; people's needs were not being met around skin integrity and nutrition and choking. We found several people were at risk of choking due to the way they were fed and we found unidentified skin damage. The provider's monitoring systems had failed to identify these risks therefore people were being exposed to the risk of harm.
- We found monitoring systems were insufficient to audit people's care records and care plans effectively. The provider had not identified where discrepencies or entries made indicated concerns in people's needs being met. For example; care plans did not reflect the care actually delivered and there was no robust response where accidents had occurred to prevent the risk of further harm to people.

The provider's failure to ensure sufficient monitoring systems were in place formed part of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Continuous learning and improving care

- We found further significant shortfalls in the provider's quality assurance and governance systems. The provider had failed to identify the widespread concerns we found during our inspection. The deterioration of some aspects of the service had caused a significant increase in the risk people were exposed to.
- We found where incidents had arisen and were known to the provider, they continued to fail to ensure appropriate action was taken to ensure people were protected from further harm. For example; where a coroner had highlighted areas of concern regarding risk management and investigations around a specific aspect of the service, the provider had failed to take any action to ensure these concerns were addressed.

The provider's failure to ensure that adequate quality assurance and governance arrangements were in place was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 Good governance.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•□While the manager and nursing staff understood there was a requirement to submit statutory notifications to CQC, they did not have a good understanding about what events needed to reported. Statutory notifications are a legal requirement where providers need to notify CQC of serious incidents such as allegations of abuse and serious injuries. We identified multiple safeguarding concerns that had not been notified to CQC.

The provider's failure to submit statutory notifications was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents.

•□Staff we spoke with were positive about the current management of the service. They told us the manager had taken steps to more clearly define the roles of staff members and they had improved supervision and support.
•□We found staff at all levels did not clearly understand the expectations of them when working in a health and social care setting. They did not understand quality performance and insufficient monitoring was in place to identify risk and to improve safety and the quality of service provided to people.
•□The provider failed to provide sufficient oversight of the management of the service and were unaware of the widespread risk and issues we found during our inspection.

The failure of the provider to ensure sufficient oversight and monitoring was in place of the management of the service formed part of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations Good governance

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•□People told us they were not sufficiently involved in the development of the service. One person told us, "I'm not involved in any decision making. We don't have any resident's meeting. I've not been asked to fill in a questionnaire. I don't get asked my opinions." Another person told us, "I don't go to any meetings. I'm not asked my opinions by the staff". Some relatives told us the prior manager had begun to hold residents and relatives meetings but these were not currently taking place.
•□The provider and registered manager were not taking proactive steps to ensure that people's views were sought, understood and that action was taken to resolve any issues identified. The provider was unaware of the concerns people raised with us during the inspection.
The provider's failure to ensure people's feedback was effectively sought and acted upon formed part of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Working in partnership with others
•□We found failings in the provider's ability to work with others in order to develop the quality and safety of people's care. For example; we found the manager had had insufficient communication with Speech and Language Therapists (SaLT) in order to establish people's needs and as a result people were exposed to the risk of serious and immediate harm. We also found instructions from Tissue Viability Nurses (TVNs) were not followed as staff felt they were not appropriate to a person's needs. They had not however, communicated these concerns with TVNs to ensure an appropriate plan of care could be developed. We found this person

in bed expressing pain and with further unidentified and undocumented skin damage.