

St. Martin's Care Limited

# Willow Green Care Home

## Inspection report

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28 June 2022

30 June 2022

04 July 2022

12 July 2022

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Inadequate** ●

# Summary of findings

## Overall summary

### About the service

Willow Green Care Home provides personal and nursing care for up to 63 younger and older adults living with a range of conditions including dementia. At the time of inspection 54 people were using the service.

### People's experience of using this service and what we found

Auditing and oversight of the service were not robust. We found issues that the provider's systems had either not identified or not corrected. The provider did not meet all regulatory requirements. The management team had planned a range of improvements, but these did not address all the immediate concerns we found.

People did not always have their medicines as prescribed or at the correct times. Systems to manage and audit medicines were ineffective and did not identify all the issues found at inspection.

Record keeping was inconsistent. Support plans and risk assessments did not always give staff clear guidance about potential risks and some plans lacked essential details. The provider had not taken enough action to reduce potential fire and safety risks. Staff were responding to safeguarding concerns where these were identified but the outcomes were not always recorded. Staff were not all trained to recognise and report abuse. In some instances where concerns were identified, lessons were learnt and shared with staff. However, this was not done routinely for all incidents or accidents.

There were not enough trained, skilled and appropriately supervised staff on duty to provide person centred care. We received feedback that people sometimes had to wait for care or there were only enough staff on duty to provide care to meet people's physical care needs. Staff rarely had time to spend with people on a one to one basis or engage in social activities of people's choice. Most people and relatives gave positive feedback about the staff who supported them and told us they were caring and worked hard to compensate for the shortage of staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, records did not always reflect discussions and decisions around this. We have recommended that the provider reviews how people's capacity and consent are recorded.

There were limited systems for collecting feedback about the quality of the service and this was not always evaluated or used to drive improvements.

Management were reviewing practices in the service and had strengthened the management structure. The provider followed safe recruitment processes and had recruited staff recently to improve the level of permanent staff working in the home and reduce the reliance on agency staff. The service worked with partner agencies and was involved in some improvement work in medicines management and with the

ambulance service to improve people's transfer to and from hospital.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Rating at last inspection

The last rating for this service was good (published 17 May 2021).

#### Why we inspected

This inspection was prompted by a review of the information we held about this service. Also, in part due to concerns received about infection control, people's nutrition and the overall management of the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We inspected and found a concern with responding to people's social needs, so we widened the scope of the inspection to include the key question of responsive.

You can see what action we have asked the provider to take at the end of this full report.

After the inspection the provider took immediate actions to address some of the concerns and further development work was planned. They continued to work with partner agencies for guidance and support. For example, in relation to fire safety and medicines management.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Willow Green Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement and Recommendations

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 take further action if needed.

We have identified breaches in relation to; governance of the service, staffing, medicines management and responding to people's social needs and preferences.

Please see the action we have told the provider to take at the end of this report.

We have made a recommendation about improvements to the processes around capacity and consent.

#### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Details are in our effective findings below.

**Requires Improvement** ●

### Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

**Inadequate** ●

# Willow Green Care 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 Health and Social Care Act 2008.

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

The inspection team consisted of three inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

#### Service and service type

Willow Green Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Willow Green Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was no registered manager in post. A manager, who had been in post since October 2021, had applied to register on 23 May 2022. This application was in progress.

#### Notice of inspection

The first day of this inspection was unannounced. We gave the provider short notice of the second day. The manager was on annual leave but cancelled this to be in the home when we returned.

Inspection activity started on 20 June 2022 and ended on 12 July 2022. Three inspectors visited the service on 20 June 2022 and two on 28 June 2022. The Expert by Experience made telephone calls to relatives on 30 June 2022 and a medicines inspector supported the inspection remotely. We continued to speak with people, relatives and staff and receive information from the service until 12 July 2022.

#### 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

#### During the inspection

During our visits we spoke with six people who used the service about their experience of the care provided and with two relatives. We looked at records relating to the management of the service. These included medicines, accident and incidents, safeguarding, recruitment and quality assurance. We looked at five people's care and support files. We spoke with 14 members of staff, including the operations manager, manager, deputy manager, clinical lead, cook, domestic assistant, senior care workers, nurses and care workers.

After the visit we continued to seek clarification from the provider to validate evidence found. We looked at quality assurance systems and training records. The Expert by Experience spoke with eight relatives by telephone. We spoke with four staff by telephone and one visiting professional. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Using medicines safely

- Medicines were not managed safely. People did not always have their medicines as prescribed or at the correct times.
- There were times when people's required medicines were out of stock. The provider was aware stock issues were on-going and had not effectively resolved these.
- Medicines records were not completed consistently. Medicines omissions were not always identified and explored.
- Where people were prescribed dietary supplements, these were administered inconsistently.
- Staff could not demonstrate that people were always getting medicines creams applied as prescribed or medicine patches applied.
- The medicines audit system did not follow best practice and did not always ensure medicines errors were identified or acted on in a timely way.
- The provider had supplied additional staff training and sought support from partner agencies to improve medicine management, but errors were still reoccurring.

The provider did not have effective systems for the proper and safe management of medicines. This placed people at risk of harm. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A clinical lead had been appointed to oversee medicines management in the service.
- Electronic medicines systems were being reviewed to ensure they supported safe practices.
- The manager continued to work with other agencies to improve practices.
- Most people and relatives told us they felt medicines were given on time. One relative told us, "I am there at lunch times and medicines come at the same time every day."

The provider responded after the inspection with further planned actions to improve management of medicines.

### Assessing risk, safety monitoring and management

- Risks to people's safety were not always effectively managed. Staff had not practiced fire evacuation and some staff told us they would not be confident doing this.
- There were increased fire risks in the building, associated with a person smoking. These had not been thoroughly assessed and reduced.



- Some doors should have been locked to ensure people's safety, but these were unlocked. For example, a door which allowed access to the mechanics of the lift.
- People's risk assessments did not always consider and reduce all risks. For example, one person's mental health needs had not been assessed so risks around their behaviours could be managed safely.
- Bed safety rails and electrical pressure relieving mattress settings were not checked frequently enough to ensure people's safety.

The provider was not doing all that is reasonably practicable to mitigate risks to people's safety. This placed people at risk of harm. This is a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Information was available on how people should be evacuated in the event of a fire. Senior staff had undertaken recent training to improve practices in this area.
- We informed the Fire and Rescue Service about our findings. They told us they planned to visit the service to complete a scheduled risk-based assessment.
- On our second visit doors had been secured for people's safety.

Systems and processes to safeguard people from the risk of abuse

- Systems for reporting and responding to abuse were not always followed and were not robustly monitored.
- A log of safeguarding alerts raised with the local authority did not correspond with safeguarding alerts on file. These records did not consistently show outcomes or how safeguarding incidents had been concluded.
- Some staff were not identified as needing safeguarding training on the home's training systems and had not received this. The provider confirmed that all staff would now receive this training.

The provider failed to maintain accurate, complete and contemporaneous records. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where safeguarding was recognised the manager reported concerns to the local authority so these could be investigated.
- The operations manager gave assurances that all staff would be allocated safeguarding training as a priority and compliance with this would be monitored.
- Most people and relatives told us they felt safe and that any concerns about their safety would be addressed. One relative told us, "Initially we had some concerns but during the last two to three months things have improved and we are happy with her safety now."

Staffing and recruitment

- There were not enough staff on duty to provide person centred care.
- People, relatives and staff told us staffing was often insufficient to meet anything but people's essential care needs, and people often had to wait for care. One staff member told us, "We just don't have enough staff, when people have to be up. You can't be in three places at once...people have to wait." We asked relatives if they thought there were enough staff to deliver care as people needed it. One relative told us, "I don't think so, it takes ages for someone to answer a call bell" and another told us, "I think they are short staffed, and they get agency in, they are not as good because they don't know where things are and the way things are done."
- Most staff told us they rarely had time to engage with people on a one to one basis. The provider had decided not to employ dedicated staff to co-ordinate activities and told us care staff did not have protected

time to engage in activities with people.

The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staffing was monitored using a dependency tool. The manager told us they would do checks of when call-bells were ringing to establish who was waiting for assistance and delegate staff accordingly.
- The provider had established safe recruitment processes to ensure appropriate pre-employment checks were carried out.
- The management had been trying to address the staffing issues and had recently recruited new care workers, appointed a deputy manager and a clinical lead. Staff told us there had been some recent improvement, but they continued to feel the service was short staffed at times.

Learning lessons when things go wrong

- Lessons were learnt from some incidents and accidents, but processes were inconsistently followed.
- Lessons learnt exercises were completed at the manager's discretion and not routinely as the provider's documentation stated they should be. The manager stated they would only complete a learning exercise for a significant event, such as an incident or accident, where they felt there would be a learning outcome.
- When learning exercises were completed information was shared with staff.

Preventing and controlling infection

- Infection prevention and control was not always robustly managed. Areas of the home required more thorough cleaning. Personal items such as towels and toiletries were stored in communal bathrooms, which increased the risk of cross infection.
- Staff were accessing testing in line with current government guidance. Staff used PPE safely and effectively and had received appropriate training.
- The provider was facilitating visits to the service. People and relatives told us they were allowed visits when they wanted, and we spoke with relatives who visited on a frequent basis. Visitors were screened for COVID-19 before entering the service.

# Is the service effective?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Systems did not always ensure people received care and support from suitably skilled and experienced staff. Agency staff did not have a formal or documented induction into the service.
- Some staff did not have essential training, such as safeguarding and fire evacuation, and systems failed to identify these as training needs.
- Staff did not all have regular opportunities for formal supervision and appraisal of their performance.
- Agency staff had been used frequently. Feedback we received was that agency staff did not always know the service and people's needs. One staff member told us, "They are different carers every time, they are from the same company but not the same carers. It can be stressful. I was doing the job and trying to show them what to do."

The provider failed to ensure staff had appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This is 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

- Systems did not ensure people were receiving balanced and appropriate diets.
- Food and fluid charts were not always completed fully and where there were gaps, there was no clear audit trail of actions taken. These records did not always reflect when people were offered calorie enhanced drinks and snacks in-line with their care plans.
- One person's diet was recorded incorrectly on the lists staff were using to prepare meals. This person had a potential choking risk if meals were not prepared correctly. However, staff we spoke with knew this person's needs.
- We received both positive and negative feedback about the quality and choice of food. One person told us, "The food is not up to scratch." Another told us, "The food is dreadful at the moment, very repetitive." However, some relatives told us their family members were very happy with the food on offer. One told us '[Person] really likes it, especially the puddings.' There were no systems to monitor people's satisfaction with the meals provided.

The provider failed to maintain accurate, complete and contemporaneous records in respect of people's care and treatment. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were processes in place to monitor people's nutritional risk, which followed best practice guidance and referrals were made to other professionals where risk was identified.

#### Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The service worked within the principles of the MCA but for some people recording did not reflect decisions made.
- We found two examples where people's consent or capacity had not been recorded or recording was not robust. For example, for one person verbal consent had been gained but records did not reflect this. For another person, records in relation to capacity were not up to date and therefore did not reflect current needs.
- For other people consent and capacity had been explored and documented. People told us that verbal consent was routinely sought at the point of care being given.

We recommend the provider reviews best practice guidance around the MCA, including how capacity and consent are assessed and recorded.

#### Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed using nationally recognised tools. However, assessments were not always accurate or reviewed.

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

- People were supported to access healthcare services and support.
- People were appropriately referred to healthcare professionals such as chiropodists and dieticians.
- The service did not always keep records to demonstrate what actions were taken when people refused appointments or if referrals for specialist services, such as falls prevention, had been considered.

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

- Areas of the service required some redecoration and refurbishment.
- For example, there were areas of chipped paint by the lifts and some sparse areas of the home, such as the downstairs lounge which had little furniture. The manager explained that there were planned improvements to these areas which were scheduled.
- Parts of the service had been adapted to better suit the needs of people with dementia. They were decorated with theme areas, contrasting paintwork and had signage to help people to orientate themselves.

# Is the service responsive?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not provided with opportunities to engage in meaningful activities and there was little social interaction between staff and people.
- There were no designated staff to assist people with activities. All staff were required to support with people's social needs. Staff did not have training around this and told us they rarely had time to spend with people.
- Some staff told us that activities, such as board games and dominoes, took place but these were determined by staff and not planned around people's preferences.
- Most people and relatives we spoke with expressed concern about the lack of social engagement offered. One relative told us, "Before [Person] came in they were a volunteer at a day centre and they did all sorts of craft things and they loved it, so it is a shame that there is nothing at the home." Another relative told us, regarding activities, that there was, "Absolutely nothing, sometimes the place is like a morgue."
- There were no specific activities records for the staff to monitor and demonstrate what activities people engaged in. We could not therefore see evidence of any cultural or spiritually appropriate support. There was no evidence that people had been asked about their satisfaction with the level of social activity in the home.

The provider failed to ensure people's personal preferences, lifestyle and care choices were met. This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager and wider management team told us that some interactive activities were available to people via the televisions in the main lounges but agreed these activities were not available to people who were cared for in bed.
- Activities was on the home's improvement plan for the coming year.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans did not always reflect people's current care and support needs.
- Care plan reviews were not always completed as required. One person's care had not been reviewed for four months and documented needs were not current. This had not been identified by the provider.
- In the other care plans we checked there were minor inaccuracies, but these generally gave details about the person and their essential needs.
- Staff told us they had enough information to support people safely, but some said written information

about people was out of date and they relied on their own knowledge of individuals.

The provider failed to maintain accurate, complete and contemporaneous records in respect of people's care and treatment. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection that they would immediately correct the issues found at inspection.

- Relatives told us they felt staff knew people's needs.

Improving care quality in response to complaints or concerns

- The service was responding to formal complaints.
- We received mixed feedback about more informal concerns raised. Most people and relatives told us if they raised concerns they would be resolved by either staff or the manager. We received some feedback, however, that people did not know the actions taken to address their concerns.

The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the manager instigated a log so that concerns and responses could be monitored and used to develop the service.

Meeting people's communication needs

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

- The manager was aware of their requirements under the AIS and information was available explaining this to visitors. Some general information about the service was available in other formats, such as easy read, and copies were on display in the reception area. Management told us if people requested a different format, it would be made available.

End of life care and support

- Systems were in place for people needing end of life care.
- People receiving end of life care had plans in place reflecting how this would be delivered.
- Most staff had training on how to support people at this time and we received some positive feedback from staff and relatives about how people were cared for. One relative said, "[Person] seems comfortable... Staff are very good. Staff wash them, give them a bed bath daily."

# Is the service well-led?

## Our findings

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

At our last inspection we rated this key question good. This key question has been rated 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

- The service was not well-led.
- The provider's systems failed to effectively monitor the safety and quality of the service. The provider had failed to ensure compliance with all the regulations.
- Audits did not reflect the findings of the inspection. Inaccuracies in auditing meant some issues were not identified and therefore no action had been taken to ensure the service was safe and responding to people's needs. The provider could not evidence they had responded to all external audits. For example, actions identified by a visiting medicines optimisation technician.
- Record keeping was inconsistent. There were gaps in records and in the planning of people's care which meant management could not be assured people were receiving the care they required.
- Records to demonstrate outcomes were at times incomplete and we received mixed responses from the people we spoke with, especially about social well-being.
- Staffing had not been appropriately managed to ensure that there were enough staff who had a mix of skills to meet people's needs. Staff were not regularly and robustly supervised to ensure issues were identified and resolved.
- The management team did not have full oversight of all systems used to manage the service. We received conflicting responses from the management team and from staff about the processes and documents in use.
- The service did not always comply with regulatory requirements. Services that provide health and social care are required to inform CQC of important events which happen in the service by submitting a 'notification'. During inspection we found the service had not informed us of all significant events.

The provider failed to maintain accurate, complete and contemporaneous records and have effective systems to assess, monitor and improve the quality and safety of the service. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- A deputy manager and clinical lead who were new in post had been delegated oversight tasks, such as supervision of nurses and responsibility for some audits. There had been little time for them to become established in their roles.
- The manager told us these roles and extra resources would help drive improvement in the home.

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

#### characteristics

- There were limited avenues for people, relatives and staff to be involved in the service and its ongoing improvement. The management sent out communications and e-mails with updates to staff and relatives. However, these were one-way communications.
- Most people and relatives told us they did not feel they had been approached or consulted with about their views on the service. There had been no recent meetings for this purpose and no recent satisfaction surveys had been sent out. Management did not respond to feedback left by visitors to the home. Concerns were not routinely logged so they could be monitored for trends.
- Meaningful feedback was not regularly gathered from staff or visiting professionals and some staff told us their feedback was not acted on.

The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives told us they could speak with staff or the manager about day to day care issues that arose and were involved in reviews of people's care.
- The manager had recently commenced holding staff meetings. They told us these would be planned regularly now the home had the management resources to do this. Equally they planned to meet with people and relatives, but this had been postponed due to the impact of the pandemic.
- A recent staff survey had been sent and results indicated 72% of the staff team were mainly happy or very happy in their roles.

#### Continuous learning and improving care

- Improvement plans did not comprehensively address the issues identified in the home. Some improvements were new and either had not been started or were not yet embedded.
- The provider had systems for continuous learning, but these were not being used consistently or to full effect.

The provider failed to have effective systems to assess, monitor and improve the quality and safety of the service. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some planned improvements were based on good practice and demonstrated working with others. The service had developed links to train nurses in the home and had two trainee nurses working with support from Teesside University.

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

- The provider was aware of their responsibilities under the duty of candour.

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

- There was not always a positive, person centred culture in the home.
- We received mixed views about the culture and ethos of the service. Some relatives and staff told us the atmosphere in the service was positive and improving. However, others and people who used the service, told us the service had no atmosphere, morale was low, and management were not responding to concerns.



Staff told us issues had been raised with the manager about the lack of joined up working between staff teams.

- One staff member told us, "Staff morale is really low at the moment. We have no support at all." One person told us, "At the minute they are using a lot of agency and morale is down."

Working in partnership with others

- The service had worked with partner agencies, specifically to improve practices around medicines management and to develop communication systems with the ambulance service to improve people's transfer to and from hospital. We received some positive feedback about the staff's willingness to engage with partners.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider failed to ensure people's personal preferences, lifestyle and care choices were met. 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not have effective systems for the proper and safe management of medicines. The provider failed to have robust systems to assess and mitigate the risks to people. 12(2)(a), (2)(b), (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service failed to keep accurate, complete and contemporaneous records regarding people's care and treatment. The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. The provider failed to maintain accurate, complete and contemporaneous records and have effective systems to assess, monitor and improve the quality and safety of the service. 17(1), (2)(a)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	<p data-bbox="836 239 1406 394">The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed.</p> <p data-bbox="836 398 1422 633">The provider failed to ensure staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.</p> <p data-bbox="836 638 994 674">18(1), (2)(a)</p>