Abi Oduyelu

Nightingale House

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
Nightingale House 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.

The care home accommodates 30 people over two floors in an older style adapted building. 22 people were living in the service at the time of this inspection.

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

People living in the service was not safe and at risk of harm. People's medicines were not well managed, and people did not receive their medicines as prescribed. The environment was not safe, and people were at risk of harm, including from the risk of fire. Lessons were not learned, and improvements were not made when things went wrong. Recruitment checks were not robust and failed to keep people safe.

Peoples care, and support was not delivered in line with current standards and guidance. People were restricted from freely moving around the service. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The provider failed to follow and act on restrictions placed on people by the authorising authorities. People were not supported by staff to eat and drink and staff failed to give people choice.

People were not treated with care, compassion, kindness or dignity. We observed staff not supporting people in a way that was caring. Many interactions by staff remained task and routine led. Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care and treatment based on people's needs and preferences. People were not supported or enabled to take part in regular social activities that met their needs. Complaints were not well managed and were not dealt with to ensure learning.
The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. The provider failed to act where concerns were highlighted by management and others and failed to have appropriate oversight. Quality assurance and governance arrangements were not in place and did not provide effective oversight. The last rating for this service was good (published 24 October 2018).

Why we inspected
The inspection was prompted in part due to concerns received about care of people, the environments and infection control. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make urgent improvements. Please see the safe sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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Enforcement
We have identified breaches in relation to medicine management, environment, oversight, governance, dignity and respect and the safeguarding of people.

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 request an action plan for the provider and meet with 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below

Is the service caring?

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

Nightingale House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an assistant inspector

Service and service type
Nightingale House 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 did not have a manager registered with the Care Quality Commission. At the time of inspection, the deputy manager had taken on the role of manager and was being supported by a previous registered manager of 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.

Notice of inspection
This inspection was unannounced.

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

We spoke with seven people who used the service and one relative about their experience of the care

provided. We spoke with seven members of staff including the provider, manager, assistant manager, senior care workers and care workers and the chef.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. 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 provider to validate evidence found. We looked at training data and policies and procedures. We spoke with four 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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not safe from the risk of harm or abuse. Systems and processes were in place to protect people. However, staff did not understand these and failed to have the required knowledge to protect people from abuse. We spoke to staff about safeguarding people and what this meant. Other staff could not tell us different forms of abuse people were at risk of nor what they would do if they had concerns.
●Lessons had not been learnt to protect people and prevent people from coming to harm. Opportunities to improve and sustain safe care had not taken place. Previous professional reports from the local authority and others had highlighted shortfalls. For example, the provider could not demonstrate that the service had taken sustained learning from support given by professionals. This resulted in our inspection identifying similar issues and concerns.

Staffing and recruitment
● Recruitment processes were not safe, and checks did not make sure the right staff were recruited to support people. We checked three recruitment files and found gaps in people's employment had not been explored and references had not been obtained prior to them starting work. We spoke to the manager who told us they were aware of this and were waiting for these to be received. One member of staff who had been employed by the deputy manager, started prior to references being received. This meant the service could not be assured that the person was of good character and safe to work with people. We spoke to the deputy manager who confirmed they were aware that these had not been received and had not completed a risk assessment."
● Not all Disclosure and Barring Service [DBS] certificates were received prior to a member of staff starting work. One person started working within the service prior to their DBS being received despite acknowledging in their application that they had a positive criminal record. We spoke to the manager who confirmed this and acknowledged no risk assessment had been completed prior to the person starting. This meant the provider could not be assured staff were safe to provide care to vulnerable people.

Whilst we did not find people had been directly harmed, people were at risk of being cared for by unsafe staff. This was a breach of regulation 19 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of inspection, there were not enough staff to support people. The provider did not ensure staff had time to give people the care and support they needed. The manager also raised concerns about staffing levels. They told us, "People aren't safe in the home. With the number of residents and the size of the building, the staffing isn't safe, and people aren't safe. I get told how many staff should be on the floor. The dependency tool to decide what staff we need is worked out by a consultant. It's not accurate."

● One member of staff told us there was not enough staff. They told us, "There are 10 people upstairs and only me to support them. One person needs hoisting and sometimes someone from downstairs helps me." A resident told us, "I do have concerns that the owner dictates the amount of staff they have, and we are often left having to wait."

Assessing risk, safety monitoring and management; Using medicines safely

● The environment placed people at immediate risk of harm. We found significant issues requiring immediate action. A fire risk assessment had been completed by an independent person in October 2019 which identified several significant shortfalls that required immediate action. Following this, the local fire and rescue service carried out an audit in December 2019 and found the service non-compliant in fire safety. When we inspected the home, we found action had not been taken by the provider to rectify these issues. This meant people continued to be at risk of significant harm in the event of a fire.

● Further environmental concerns were also highlighted during the inspection. This included exposed radiators, corroded and leaking pipes and excessive hot water temperatures. For example, running water temperatures in several bedrooms were extremely hot and posed a significant risk to service users of scalding. We identified that this concern had been raised previously within the home during the legionella risk assessment of the building in March 2019 and during visits by the local authority prior to the inspection. During the inspection, the manager and support manager could not demonstrate that the appropriate works had been carried out or that risk to service users had been mitigated for scalding.
We wrote to the provider and asked for this to be addressed immediately to mitigate any risk posed. The provider responded immediately, and confirmed actions would be completed.

● Risk assessments relating to the environment were not robust enough to mitigate risk to people. This included Personal Emergency Evacuation Plans (PEEP) for use in case of an emergency. PEEPs were in place for people however, lacked detailed information for staff to follow in an emergency. For example, two people had been assessed as requiring the use of a mattress to evacuate from upstairs bedrooms. We spoke to staff who told us they did not understand how to safely do this and had not received training.

● Medicines were not safely managed. People did not receive their medicines as prescribed. For example, one person told us they had not received medication to support their breathing. They told us, "I'm supposed to have it four times a day. Even if they would give it to me twice a day that would be something. But I haven't had it." An audit of medicines found that their medicines were not in stock and had not been administered. We immediately raised this with the manager and asked for the GP to be contacted. Another person told us they were concerned that they had not received their medication from staff. They told us, "When tablets run out you can wait up to a week to get a new prescription. It's frightening because I'm on heart tablets." We immediately spoke to the manager who did not know what had happened and spoke to the GP who confirmed these had been stopped. This meant staff had not spoken to the person to inform them what was happening with their medicines. We asked the manager to immediately speak to the person to offer reassurance.

● We completed a stock check and found multiple people's medicines had not been administered. For example, one person was prescribed a transdermal opioid patch for pain relief, prescribed to be administered every seven days. Records showed that on two occasions, the person received the patch a day late. We spoke to the manager and support manager who were unable to tell us why this had happened. This meant the person was at risk of suffering breakthrough pain.

● Where people received their medicines covertly, the service had not followed national guidance to ensure this was done safely. For example, one person was prescribed medicines covertly to be administered in food or drink as agreed by the GP and pharmacist. However, senior care staff told us they crushed all medicines together and administered dry on a spoon. This meant that the person was not then receiving their medicines covertly and had continued to refuse.

● Medicines administration records, [MAR} were not kept in line with national guidelines. Records showed that staff had not recorded amounts of medicines received into the service. This meant staff would not be able to easily check and audit what medicines there were in stock and if people had received these as prescribed

In response to the shortfalls we identified during this inspection, we raised a safeguarding referral to the Local Authority. We also referred the service to the medicine's optimisation team for further support

Whilst we did not find people had been directly harmed, the risk of harm had not been mitigated to keep people safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The environment was not clean. The home employed a cleaner for five days however, the manager told us this was not enough to keep the home clean. The manager told us, "The cleaner only does 9 am until p.m. I have said to the owner it's not enough."

● The home did not follow infection control measures. For example, we found dried faeces on toilet seats throughout the home as well as faeces in waste paper bins. We raised this with the provider and manager who told us they were not aware of this. These concerns had not been identified by the provider or management in the service

● People could not always access hand washing facilities. For example, one person told us they were concerned about their hand hygiene and had not been supported to manage this. They told us, "Sometimes I have to dip my hands in my jug of drinking water. I can't get up to use the sink. I have asked them for a bowl to wash my hands, but they haven't given me one."

Inadequate

Is the service effective?

Our findings

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

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

This meant there were widespread and significant shortfalls in people's care, support and outcomes

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People were restricted from moving freely around the service. We observed care staff consistently telling people to sit down when they stood up. Care staff placed bed tables in front of people to prevent them from moving freely. This meant people's freedom of movement was restricted. We spoke to the manager and support manager about this. They told us they were not aware of this practice and it had not been identified as a concern. However, information of concern had been raised previously by the local authority in this regard to the home.
- Where people had their liberty lawfully deprived, conditions placed on the home by the authorising body had not been followed. This meant that people were being unlawfully deprived of their liberty. For example, one person's DoLS condition required the home to inform the person and family of the use of CCTV. We spoke to the manager and provider who confirmed that this had not taken place.
- CCTV was used throughout the home's communal areas. We checked people's care records which confirmed people had not consented to this. This meant we could not be assured that people and their families were aware of these cameras. A policy for the use of CCTV was in place however, the provider could not demonstrate this was being followed
- Staff told us they had received training in MCA and DoLS. However, observations of staff practice showed they did not understand this.

The failure to ensure care and treatment was provided in line with the Mental Capacity Act 2005 where people could not provide informed consent was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The manager understood their responsibility to apply for DoLS. However, they did not understand their responsibility to inform CQC when applications had been granted.

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

● At the last inspection, we found improvements were needed to ensure the suitability of the premises for people living with dementia. The provider told us furniture would be replaced in the next financial year as part of their ongoing improvement and replacement programme. At this inspection, we found that these improvements had not been made and the environment was poorly maintained. We identified flooring in people's toilets were not always fitted properly. This presented a risk of infection control and trips to people when in their bedrooms. In communal areas, we identified flooring either raised or dipped creating a divot in the floor. This meant people were at additional risk of falling when moving around the home. We immediately raised this with the provider and showed them our findings. They told us they were not aware of this.

● The environment had a strong odour of urine throughout. We raised this with the manager who told us, "Its 100% smelly here. We use lots of air fresheners around to fight it. Problem is, the smell is soaked through to the lino and its already underneath."

We found no evidence that people had been harmed. However, action had not been taken to demonstrate the environment safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not supported to eat or drink enough. For example, we observed one person not liking the food they had been given at lunch including dessert. The food was removed from the person and they were not offered anything else. We identified one person had fluids in their rooms. On checking, we found their juice had significant mould spores growing on top of this. This person was independent and was able to get drinks for themselves. We immediately raised this with the manager and provider who were unaware of this.

● People were not supported to have choice over their food and drinks. During lunch, staff did not offer people a choice of meals. People were observed to all be given gravy on their food regardless of whether they had asked for this. Staff did not ask people if they wanted drinks and these were given regardless of choice

Where concerns were raised about people's food and fluid intake, charts were not always in place for people who were at risk.

Whilst we did not find people had been directly harmed, people were at risk of not receiving their required nutrition and hydration. This was a breach of regulation 14 (Nutrition and hydration) 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

● People's needs were not always assessed in line with standards, guidance and the law. The quality of assessments and care plans were inconsistent, some were detailed whilst others did not provide enough information to guide staff in the support people needed. For example, one person had received pressure injuries prior to admission to the home. A skin and pressure ulcer assessment was in place but lacked information on how to support the person to recover nor what measures should be in place to reduce risk for this person.

Staff support: induction, training, skills and experience

● We received mixed feedback from staff about training. Some staff felt the training was not enough to ensure all staff had the right skills. One staff member told us of their concern that staff were inexperienced and told us "They [managers] hired people with no experience and haven't trained them properly."

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

● People were supported to access external health services such as District Nurses and GP's. However, one member of staff expressed concerns that night staff were not well trained and were unable to assess people's health needs in order to gain prompt medical attention.

Inadequate

Is the service caring?

Our findings

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

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

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

● People did not receive a service which was caring as they were not protected from potential risks, as documented throughout this report.
● Staff failed to treat people with kindness, respect and compassion. One person told us, "People think it's lovely here but it's not. It's what they [staff] want to do, not what you want to do. I can't wait to get out of this place."
Management and staff raised concerns about the quality of staff employed in the home. The manager told us, "There are only a few staff here that I would have caring for people if I had my way. The biggest problem with the home is not having the right staff to look after people. I wouldn't put my mum in here, no way. I would take her out straight away and go somewhere else."

● Staff were task focused. Staff failed to provide care and support in a compassionate and supportive way. Staff were observed to have an ingrained culture of poor practice and demonstrated a lack of compassion for the people they were supporting. For example, one person called to staff, "Please, where am I? I want to go to bed. I want to die'." A member of staff was present and did not offer any support or reassurance and continued to ignore the person for four minutes. At this point, the person became distressed and when the person stood up, was repeatedly and aggressively told to sit down. We observed the member of staff responding by giggling and tutting with their teeth at the person who was distressed.
● Where a person's religion had been identified in their care plan, there was no information provided on how to support that person to continue following that religion or how their religious and spiritual needs should be met.

Respecting and promoting people's privacy, dignity and independence
● People were not supported to maintain to their independence. For example, sinks throughout the home did not have plugs in them. This meant people could not maintain their personal hygiene independently. Care records did not always show what people would have been able to do for themselves.
● People who tried to stand up from their chairs in the lounge were told to sit down. Most people had lap tables in front of them and we observed that when one resident kicked hers away to stand up, was told to "Sit down" and had the lap table put back in front of her.

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

- Observations during the inspection showed people were not offered choices about their day to day care.

The service failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care records showed people had not been involved in the review of their care.

Inadequate

Is the service responsive?

Our findings

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

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

This meant services were not planned or delivered in ways that met people's needs.

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

- People's care plans documented people's choices and preferences. However, through observations of staff interaction with people, we saw this was not adhered to by staff.
- People were seen to receive institutionalised care and to be restricted in their movements. This meant that people did not have choice and control over the care that they received and that their wishes were not respected.
- People who may exhibit distressed or anxious behaviour did not always have behaviour support plans or guidance for staff on how to support people. People's behaviours had been documented but there was no analysis of what had caused the behaviour or how the person had been supported into wellbeing.
- People's care records lacked information about their life histories. This meant it was difficult for staff to understand people's background and meaningfully engage with them about this.

Meeting people's communication needs

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

- People communication needs were not met. One person was observed to having significant hearing impairment and was known to repeat themselves. Information about this was not identified in their care plan. We observed staff becoming agitated with people
- The home did not have appropriate signage in place to support people to independently access different areas of the home.

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 did not have the opportunity to take part in activities in the home. There was no activity schedule in place, and we observed limited interactions taking place on the day of inspection. A relative told us, "I don't see anything happen. I saw someone playing cards with a resident, but I've never seen that before today."
- People were seen to spend much of the day asleep in the lounge and did not receive adequate stimulation or interaction from staff.
- There was not a designated activity worker at the home. The manager told us that they would ideally,

"Want an activity co-ordinator every day. Then weekends would be my staff [providing activities]."

Improving care quality in response to complaints or concerns

● We saw evidence that complaints had been investigated and responded to by the service. However, some of the issues identified included the negative attitude of staff members and concerns regarding the cleanliness of the home. On this inspection we found that these concerns were still an issue. This meant that the service had not learnt lessons from complaints received or improved the care quality as a result.

●One person told us that they had made complaints about aspects of their bedroom and that these complaints had not been addressed. They said, "Firstly, the window here, there's a freezing cold draft. I've mentioned it but nothing's been done about it. And secondly my reading. As you can see, I love to read, I have lots of books but my light up there isn't bright enough to read. Again, I've told them, but nothing's been done." This complaint was not recorded in their complaints log and therefore we could not be assured that the service was adequately addressing and acting on all complaints. During the inspection, we found a number of people's bedrooms were without a main source of light due to broken light bulbs, but these had not been fixed.

End of life care and support

● Information about how the person wanted to be cared for at the end of their life was not in place. For example, one person had a Do Not Attempt Resuscitation (DNACPR) in place but there were no details about their end of life wishes.

● There was limited evidence that people are been consistently consulted about their end of life wishes. One person's end of life plan documented that the person had been asked about their wishes but had not wished to discuss this. However, there was no evidence of a conversation being had since or of contact being made with the person's family.

Inadequate

Is the service well-led?

Our findings

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

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

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The service did not have a manager registered with the Care Quality Commission (CQC). Registered manager's 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 inspection, the service was being run by the deputy manager, the owner and a previous home manager.
- The management team lacked oversight on what was happening in the service. Where medicines had been identified as 'make available' by staff, this had not been communicated to the management team and no action had been taken to rectify this.
- Where shortfalls had been identified by the inspection team that the service was already aware of, action had not been taken to address these issues.
- Risk management was poor. For example, staff had documented when people had fallen but there was no analysis of this information to try and prevent incidents from reoccurring. A high number of these falls had been unwitnessed, but no action had been taken to investigate and address this. People who required behaviour support did not have accurate records which detailed what was happening before the event or what measures were taken to support this person. There had therefore been no analysis of what may have triggered the person to become upset, in order to better support that person in the future.

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

- The leadership and overall management of the service was inadequate and had failed to ensure the service was consistently well-managed and led at both provider and service level.
- The service did not achieve good outcomes for people because the care was task focused and was not empowering of people. People were seen to have their rights to freedom of movement restricted as they were forced to stay in their armchairs by the placement of lap tables. People when they tried to stand up, were berated by staff and told to sit down.
- Staff morale was very low at the service. One staff member said, "I think if we had happy staff, we'd have a happy home. But at the moment staff are not happy."
- Some staff were observed to be rude to people using the service and did not display a caring attitude.

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 did not always understand or act on their duty of candour. Where a person's medicine had been missing from the home, they had not had any communication with this person to reassure them and discuss actions. The person said, "It's frightening because I'm on heart tablets and I don't know how important they are but I presume quite important" This meant that the service was not acting on their legal responsibility to be open and honest with people when something goes wrong and did not think about the emotional impact it would have on the person.

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

● There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home. The manager said that they were due to have a meeting this month to discuss trips outside the home.

Continuous learning and improving care

● The service did not demonstrate that they had learnt lessons when issues were identified.

● Complaints around the attitude of staff had been received and initially dealt with by the service. However, on inspection we found that the attitude of some staff when interacting with residents was not kind or considerate. One relative said to us, "People need to receive a bit of kindness. I have seen people speak unkindly to people a little while ago I did mention that." This meant the service had not learned lessons from these complaints or taken appropriate action to improve the quality of care."

● Where environmental concerns had been raised by external professionals as well as within the home, these issues had not been addressed and subsequent concerns were found on our inspection. For example, the fire service had identified some potential issues on their inspection of the home. These issues had not been rectified and we found similar and additional concerns on our inspection relating to the safety of people in the event of a fire. This meant that the service had not learnt from this concern and had taken no action.

Working in partnership with others

● There was limited engagement with other organisations, agencies or networks to share best practice, expertise or resources to improve the service and deliver a good experience of care for people. Where professionals were working with the service, the home did not work in a collaborative way to ensure people received good quality care.

Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The service failed to ensure people were treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to ensure care and treatment was provided in line with the Mental Capacity Act 2005 where people could not provide informed consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service failed to ensure people had choice and access to nutrition and hydration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises used by the service were not properly maintained and failed to maintain standards of appropriate hygiene

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person was failing to ensure people's safety from the risk of fire, unsafe medicine practice and unsafe staffing levels.

The enforcement action we took:

We stopped the provider from taking new placements

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the provider's quality and assurance processes to operated effectively to guarantee compliance with regulatory requirements and ensure people are safe from harm.

The enforcement action we took:

We stopped the provider from taking new placements