Willow View Care Limited

Willow View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Willow View Care Home is a residential care home providing personal to up to 77 people. The service provides support to older people, some of whom may be living with a dementia, physical disability or sensory impairment. The home is divided into 2 areas: Willow View and Willow Gardens. The 2 areas are joined by a covered walkway, and both areas comprise of 2 floors. At the time of our inspection there were 69 people living at the service.

People's experience of using this service and what we found
The service was not safe. Risk assessments were either not in place or were not accurate. Checks to ensure the environment and equipment were safe had not been completed or were completed inconsistently. Fire exits were blocked throughout the service.

Medicines were not stored, recorded or administered safely. People were regularly not given their prescribed medicine due to poor stock management. Prescriber instructions had not always been followed which placed people at risk of harm.

Infection, prevention and control measures in place were insufficient. PPE was not being stored appropriately. Some elements of the environment were not suitable for people living with dementia. We have made a recommendation about this.

Safe staffing levels were not always in place. A dependency tool was used to calculate safe staffing levels, but the data used was not accurate.

People were not always treated with dignity and respect or involved in discussions about their care and support needs.

Records in all areas lacked up to date, person-centred information. Monitoring records had not been completed consistently and we could not be assured people were receiving appropriate care and support.

When complaints had been raised, thorough records had not been kept to evidence all areas of concern had been fully investigated.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's communication needs were not always met. Menus, picture menus and information in an easy read format were not available. We have made a recommendation about this.

Lessons had not been learnt when things went wrong. There was a significant lack of registered manager and provider oversight. The quality assurance processes in place were not effective and failed to identify and address shortfalls in a timely manner.

People did say they felt safe living at the service, and they enjoyed the activities on offer. People spoke highly of their regular staff for their caring approach.

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

Rating at last inspection and update
The last rating for this service was requires improvement (report published 29 April 2022) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection, we also recommended the provider made improvements to ensure a dementia friendly environment was in place and the Mental Capacity Act 2005 was followed. At this inspection we found the provider had not taken action in relation to the recommendations made and no improvements had been made.

Why we inspected
The inspection was prompted in part due to concerns received about medicines, staffing levels and systems used to monitor the quality and safety of the service. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with capacity, consent and person-centred care so we widened the scope of the inspection to become a comprehensive inspection which included all key questions.

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.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to dignity and respect, consent, assessing risk, medicine management, records and governance systems at this inspection. We have also made recommendations in relation to creating a dementia friendly environment and meeting people's communication needs.

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
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 take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring 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 View 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
This inspection was carried out by 4 inspectors, a pharmacy inspector and an Expert by Experience over a 4-day period. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Two inspectors and a pharmacy inspector visited the service on the first day. On the second day the pharmacy inspector returned. On the third day, 2 inspectors visited the service. One inspector visited the service on the fourth day of inspection to collect documentation that was not available electronically. The Expert by Experience contacted people and relatives by telephone to gather their views on the service provided.

Service and service type
Willow View 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 View Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage

the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. We were notified by the provider that the registered manager had left the service shortly after the inspection took place.

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 (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
We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at 5 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 also reviewed.

We spoke with 13 people who used the service and 6 relatives about their experience of the care provided. We spoke with 9 members of staff including the registered manager, deputy manager, senior carers, care staff, maintenance person and the chef. We also spent time observing staff interactions with people and conducted a tour of the service. Following the inspection site visit we received feedback from a further 4 staff.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last 2 consecutive inspections the provider had failed to demonstrate that safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people had either not been assessed or not enough information had been provided to enable staff to safely manage and reduce risks.
- Two people who had moved into the home in March and April did not have care plans or risk assessments in place despite there being known risks in relation to moving and handling and special diets.
- At the last inspection it was identified that risk assessments in relation to specific medical conditions, such as diabetes, were not in place. This issue remained at this inspection.
- Checks in place to ensure the environment remained safe had not always been completed. Window and fire door checks did not include windows and doors in people's bedrooms and electrical appliance testing had not been completed.
- Adequate fire safety checks were not completed. Fire exits were blocked, and personal emergency evacuation plans were either not in place or did not reflect a person's current needs.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Using medicines safely
At our last 2 consecutive inspection the provider had failed to administer and manage medicines safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Medicines were not stored, recorded or administered safely and there had been no improvement in staff practice since the last inspection.
- We found examples where people had not received their medicines as prescribed. Records showed on a

regular basis, medicines could not be administered as there was no stock available within the home, but little action had been taken by staff to address this.
● Some people had not received their medicines as prescribed because staff had failed to follow prescriber instructions. Medication that should not be administered at the same time due to how they react, had been administered together.
● Appropriate action had not always been taken when medicine concerns were identified.
● Where people were prescribed medicines to take as and when required, appropriate guidance was not in place to enable staff to understand when this should be given.

Systems were either not in place or robust enough to demonstrate medicines were safely and effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe car and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. Areas of the home were unclean and recent IPC audits had not been completed.
● We were not assured that the provider was using PPE effectively and safely. PPE was incorrectly stored and there was a lack of appropriate waste bins to dispose of used PPE.
● We were not assured that the provider was responding effectively to risks and signs of infection. There was a lack of evidence that effective cleaning had taken place.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found dirty items throughout the home.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.
● We were somewhat assured that the provider's infection prevention and control policy was up to date, although this had not been followed.

Failure to assess the risk of preventing, controlling and spreading of infections is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service.
● Visits to the home were not restricted in anyway.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to safeguard people from the risk of abuse; these had not always been followed. Professionals raised concerns that potential safeguarding's were not always appropriately reported.
● Safeguarding records in place lacked detailed information regarding the allegations, action taken and any lessons learnt.

Failure to operate effective systems and maintain complete and accurate safeguarding records was a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People told us they felt safe living at the service. Comments included, "There are some lovely staff who will do anything for me. They make sure I am safe."

Learning lessons when things go wrong

● Lessons had not been learnt when things went wrong.

● Concerns identified at the last 2 inspections had not been addressed and further deterioration was found at this inspection.

● Accidents and incidents had been recorded. However, no analysis had taken place to identify any patterns or trends. It was not clear that appropriate action had been taken to further reduce risks.

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

Staffing and recruitment

● Thorough recruitment records had not always been kept to evidence the providers recruitment policy had been followed. Some recruitment files were incomplete, and the registered manager did not have effective systems in place to ensure proper pre-employment checks had been completed prior to employment commencing.

Failure to operate effective systems and maintain complete, accurate and contemporaneous records in relation to recruitment was a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Rotas showed the required level of staff had not always been maintained. There were numerous examples in April when staffing was below expected levels.

● There was a dependency tool in place which was used to calculate the required level of staff. However, this had not been completed appropriately to reflect peoples care and support needs and we found a number of errors.

● People, relatives and staff told us there was not enough staff on duty to meet their needs. Comments included, "We sometimes only have 5 staff on duty at night. That is 1 carer per unit and a floating senior. A lot of people on the unit I work on need 2 staff to support them which you can't do with only 1 member of staff. People don't always get the support they need. I have raised it with management."

Failure to ensure a suitable number of staff were on duty to meet people's needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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

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

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

At our last inspection the provider did not have systems in place to evidence risks were robustly managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider was not adequately assessing people's needs and choices. Care plans and assessment were still not in place for specific medical conditions despite this being highlighted at the last inspection. Some people had no care plans or assessments in place.
- Care was not being delivered in line with standards, guidance and the law. Several breaches of regulation were found at this inspection.
- There was a lack of recorded evidence that appropriate assessments had been completed to ensure the home could meet people's needs prior to them moving to the service.
- Staff told us admissions to the home were not always safely managed and they did not always have time to complete the required assessments.

Failure to assess and do all that is reasonably practicable to mitigate risks was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

At our last inspection we recommended the provider considered best practice guidance, and reviews and strengthens their documentation relating to the MCA to ensure that records evidence how staff are following the principles of the MCA. The provider had not made improvements.

● Consent to care and treatment was not always in line with the law and guidance. We found examples where consent had been signed by people who did not have the legal authority to do so. Some consent forms had been signed by people who lacked capacity.
● Where people lacked capacity, decisions made in people's best interests were not sufficiently recorded. For example, when medicines were being administered covertly, there was no evidence to show relevant professionals, relative or advocates had been involved in the decision.
●Where people required a DOLS, appropriate authorisations were in place. However, records were not kept up to date so we could not be assured DOLS renewals were being requested in a timely manner.

Failure to act in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection we recommended the provider considered best practice guidance to help create a more dementia friendly environment. Some improvements had been made, but further improvements were needed.

● The design and décor did not always meet people's needs.
● The dementia unit had areas which did not provide adequate lighting. There was still a lack of sensory items for people living with dementia to interact with.
● Some dementia friendly signage was in place, which helped people navigate around the service.

We recommend the provider considers best practice guidance to help create a more dementia friendly environment.

Supporting people to eat and drink enough to maintain a balanced diet
● Records were either not in place or did not always accurately reflect people's nutritional needs. For example, one person moved to the service in March 2023 and required a special diet due to choking risks, but no care plans or risk assessments were in place.
● Where people were at risk of dehydration, appropriate monitoring was not always in place.

Failure to assess, monitor and mitigate risks to people was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed feedback regarding the meals on offer. Comments included, "The food is alright, could be a lot better" and "I have complained about the food before."

Staff support: induction, training, skills and experience
● New staff had been provided with an induction into the role. This included shadowing more experience

members of staff. However, the skills mix of staff on duty had not always been considered.

● A training program was in place to ensure staff completed all required mandatory training. There was a lack of observations of staff practice being conducted to ensure staff were following best practice guidance and were competent in their roles.

● The skills mix of staff had not always been considered when deploying staff.

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

● Some professionals shared concerns about delays in staff and management identifying and reporting issues in relation to medicine management.

● Care plans had not always been updated to reflect the guidance provided by professionals.

● Staff had contacted other professionals in a timely manner when they had concerns about people's health. For example, staff had contacted the occupational therapist when a person was experiencing difficulties with mobility.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect and their independence was not always promoted.
- The use of CCTV was in operation throughout the home, but appropriate guidance had not been followed to ensure this was safe, lawful and appropriate.
- Staff described how they were unable to meet people's care and support needs due to low staffing levels. Comments included "We don't always have time to change people's incontinence aids or get people out of bed because there isn't enough staff to support people" and "We have run out of incontinence aids before; it's happened a few times."
- Observations showed people were not always cared for in a way which promoted their dignity. For example, in 1 bedroom we observed a person's dentures that were unclean and had been left on the persons wheeled walker. In another bedroom we found faeces on the bedding which had not been replaced when the bed was made.

Failure to treat people with dignity and respect and ensure privacy and autonomy were maintained is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People spoke highly of their staff team and the care they provided. Comments included, "The regular staff are lovely and very caring." A relative told us, "Staff will go above and beyond. Its [Person's name] birthday soon and staff have offered to get a cake and sort balloons and things."

Ensuring people are well treated and supported; respecting equality and diversity
- Staff were not always attentive to people's needs. For example, we observed one person sat waiting for a cup of tea for a long period of time before inspectors had to assist. Another person stated they wanted a shave but did not have access to a mirror.
- Staff reported that they had to work in a 'task orientated way' due to low staffing numbers. Comments included, "We don't have time to sit and chat with people." This had a negative impact on people. One person told us, "Staff are rushed off their feet. There is no time for them to chat, but they try their best. It's not their fault."
- People were not always supported in line with their care plan. One person told us, "I like to get up for lunch but they (staff) have told me they don't have enough staff, so I have to stay in bed."

Failure to treat people with dignity and respect and ensure privacy and autonomy were maintained is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
- We observed staff seeking consent or consulting with people about how they wished to spend their day.
- There was a lack of recorded evidence that people, or where appropriate relatives or advocates, had been involved in the creation of people's care plans.

Requires Improvement

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.

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

- Records in place were not person-centred and did not meet people's needs and preferences.
- Some people did not have any care plans in place. Other care plans contained conflicting information. For example, 1 person's nutritional care plan stated they needed to be weighed weekly, but in another recorded it stated they were weighed monthly. It was not clear which record was accurate.
- Life history documents were in place, but these had often not been completed and blank versions were in people's care records.

Failure to maintain accurate, completed and contemporaneous records was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they received personalised care that reflected their needs and wishes as staff were familiar with them. One person said, "They know I am not an early bird so they check on me but if I am not awake they leave me and come back a bit later."

Improving care quality in response to complaints or concerns

- Complaints and concerns had not always been appropriately recorded.
- Where people or relatives had raised concerns, thorough investigations had not been recorded to evidence all elements of the complaint had been investigated in line with the providers policy.

Failure to maintain accurate, completed and contemporaneous records was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives knew who to speak to if they had any concerns. Comments included, "I would speak with the manager" and "I would raise it with the manager. I am not sure of their name; I think they are new."

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. The Accessible Information Standard 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.

- People's communication needs were not always met. There was a lack of available resources such as menus, picture menus and information presented in an easy read format.

● People's communication care plans lacked person-centred information. Records did not reflect the best way to communicate with individuals.
● The provider had recently invested in a new policy and procedure system which would allow easier access to accessible information.

We recommend the provider considers current best practice guidance in relation to accessible information and takes action to update their practice accordingly.

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 supported to develop and maintain relationships. Relatives and friends were welcome to visit the service at any time.
● An activities program was on display in the service, and we observed people enjoying the activities on offer. A relative told us, "The entertainment person does a good job. There is usually plenty on offer."
● There was a lack of activities and available resources for people living with dementia. We discussed this with the registered manager who stated improvements were ongoing in this area.

End of life care and support
● Person-centred records were not always in place in relation to end of life care and support and people's wishes. Some people did not have end of life care plans in place.
● People were supported at the end stages of their lives. Relatives had praised staff for the care they provided to their loved ones.
● Staff had received training in end of life care and support and spoke with care and compassion about how they supported people to meet their wishes.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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

At our last 2 inspections the provider had failed to effectively oversee the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Quality assurance systems were not effective and had not been completed on a regular basis to effectively monitor the quality and safety of the service.
● Audits that had been completed did not identify the significant issues we found at this inspection. Some audits, such as care plan audits, had not been completed for a number of months. Audits to monitor the safety of equipment did not cover all required areas putting people at risk of harm.
● There was a lack of provider oversight. The provider employed an external consultant who visited the service weekly, but their visits were not recorded. They failed to identify the shortfalls found at this inspection.
● Records did not reflect people's current care and support needs. Monitoring documentation, such as reposition records, had not been consistently completed. Care files and staff recruitment files were very difficult to navigate with important information missing.
● The issues found at the last 2 consecutive inspections had not been addressed and the service had further deteriorated. The registered manager was open and honest throughout the inspection process, but they failed to fully understand the risks implicated with the shortfalls we found.

Failure to operate effective systems and processes to monitor the quality and safety of the service provided and failure to maintain accurate, completed contemporaneous records was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others
● The service had not improved since the last inspection and no improvements had been made. The provider had failed to follow their own improvement action plan to ensure compliance with regulations.
● A new manager had been in post since February 2023, but they had failed to take swift action to identify,

and begin to address shortfalls.
● Prior to this inspection, professionals had raised significant concerns in relation to medicine management. The local medicine optimisation team were providing support with improvements. However, the registered manager had failed to respond to guidance provided and significant concerns remained at this inspection.

Failure to operate effective systems and processes to monitor the quality and safety of the service provided, and failure to evaluate and improve their practice was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider was responsive to the concerns found and agreed to review the management structure in place. They informed CQC they had appointed an external consultancy to support with the improvements needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Prior to, and during the inspection, staff described a poor culture within the service. There was a lack of confidence in the management team. Comments included, "I think they (management) are trying, but they don't really listen to what staff say. I've never seen the home this bad to be honest."
● Although staff morale was low, staff were keen to ensure improvements were made. The registered manager stated they would be implementing clear lines of responsibility to empower staff and begin to improve the culture.
● People and relatives told us they were able to provide feedback. One person said, "We have had questionnaires in the past, but I can't recall having one recently."
● Surveys had historically been distributed to people but there was no evidence of action taken as a result.

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 registered manager had not always been open and honest when things went wrong. Where safeguarding concerns had been raised, there was a lack of evidence people and relatives had been informed.
● Professionals raised concerns that the registered manager had not always been open and honest. Professionals described difficulties accessing and gathering information and a lack of acceptance by the registered manager when issues were found.