Silverdale Care Homes Limited

Silverdale Nursing Home

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
Silverdale Nursing Home is a care home providing personal and nursing care to up to 27 people in one adapted building. The service provides support to older people some of who are living with dementia. At the time of our inspection there were 22 people using the service.

People's experience of using this service and what we found
People were not safe and were not protected from abuse. Accidents and incidents were inconsistently managed and safeguarding referrals were not made when they were needed. Risks to people were not always assessed and were not reviewed when needed. People's clinical needs were not managed safely. Medicines were not stored safely which may have affected their efficacy and placed people at risk. The home was unclean and poorly maintained. Infection prevention and control practices were insufficient to keep people safe. Where things went wrong, no action was taken to address it and mitigate risk to people.

People's current needs were not fully assessed, and their diversity was not explored. People's assessments were inconsistent, and it was unclear how their assessed needs had been determined and whether there had been professional input. People were supported by staff who were not adequately trained to meet their needs and had little support to ensure they were competent. People were not supported to eat and drink in a way that met their dietary preferences. People had experienced a significant amount of unintended weight loss, but no action had been taken to address this. People were not supported to access health professionals in a timely manner which placed them at risk. The home had not been adapted to meet the needs of people living with dementia.

People were not treated with dignity and were not well treated. People were supported by staff in a task centred way that failed to respect their individual needs. People were supported with some personal care tasks with the door open which did not maintain their privacy. People were not supported to be involved in their own care and express their views.

People were not given choice and control and involved in planning their own personalised care. Care was delivered in a task centred way. People's care plans were not always current and were inconsistent which meant staff did not have clear guidance to follow to meet people's needs. People were not always supported by staff who communicated with them effectively. People felt isolated and were not supported by staff who engaged positively with them. People were not encouraged to participate in activities of their choice. A complaints policy was in place but where a complaint had been made, this had not been followed. People's end of life care needs were not consistently considered.

There was little management oversight at the home. The home had a poor culture and some institutionalised practices remained in place. Staff and the registered manager were unaware of their roles and responsibilities which placed people at risk. Systems in place to check the quality of the service were minimal and failed to identify concerns meaning they were not addressed. Systems in place to monitor

accidents and incidents were inconsistent which meant that risk was not managed effectively. The provider failed to seek feedback from people at the home, their relatives and staff to improve outcomes for people. The provider and registered manager did not engage in learning to improve the quality of care. The provider did not work positively with other agencies and failed to submit mandatory COVID-19 data when required.

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.

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

Rating at last inspection
The last rating for this service was good (published 8 March 2018).

Why we inspected
The inspection was prompted in part due to concerns received about how risks were being managed at the home and concerns around people being unlawfully restricted. A decision was made for us to inspect and examine those risks. We initially intended to undertake a focused inspection to review the key questions of safe, effective and well-led only. However, due to concerns we identified during inspection, we undertook a fully comprehensive inspection and reviewed the key questions of caring and responsive.

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 have found evidence that the provider needs to make improvements. Please see 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.

The provider has taken some immediate action and has given assurances that steps have been put in place to mitigate immediate risk to people. The provider immediately implemented a fire safety induction for agency staff at the home and all staff were provided with fire safety cue cards which guided them how to respond in the event of an emergency. Rotas were also amended to ensure that all shifts had staff allocated to them who were trained in fire safety. A rota was also put in place to provide management cover to ensure that one of the consultants or management from the provider's other home were overseeing the location each day. The provider has given us assurances that they will contact CQC immediately if there is any intention for the consultants to no longer be supporting the home.

Enforcement
We have identified breaches in relation to people's safe care and treatment, safeguarding, obtaining people's lawful consent, treating people with dignity and respect, supporting people to eat and drink, the home environment, management oversight of the home and having competent and well trained staff who can meet people's needs safely.

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?

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.

Silverdale Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Silverdale Nursing 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. Silverdale Nursing 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 a registered manager in post. However, they resigned their position on the second day of inspection.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 12 April 2022 and ended on 13 April 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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who lived at the home, four relatives and three visiting health professionals. The Expert by Experience also spoke with three additional relatives by telephone. We also spoke with an agency nurse, 3 care staff and the registered manager.

At the time of inspection, the provider had employed a health and social care consultancy to support with the management of the home and one of the consultants had registered as the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the nominated individual, another consultant and the registered manager from the provider's other care home who was also supporting with managing the home.

We looked at seven people's care records in detail. We also looked at specific aspects of people's care records where we had identified risk and reviewed five medicine administration records (MARs). We also viewed three staff files.

We asked the nominated individual to send us further assurances around fire safety and the steps they intended to take to mitigate immediate risk. This was provided immediately and received while we were still on site.

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 good. At this inspection the rating has changed 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; Assessing risk, safety monitoring and management

- People were not safe. One person told us they stayed in their room as they felt safer there.
- Systems in place did not safeguard people from the risk of abuse. Training records showed that all but one permanent staff members were not up to date with their safeguarding training and they did not always respond appropriately to abuse or allegations of abuse. For example, where a service user had repeatedly hit other people residing at the home, it had been recorded on an accident and incident form, but this had not been escalated and no safeguarding referrals had been made. This meant people were left at risk of further harm.
- Risks to people were not managed safely. For example, it had been identified in one person's daily essential health monitoring records that there was a concern which may have had a negative impact on their health. Although staff were monitoring this, they had not taken action to intervene which posed a risk to the person's physical wellbeing.
- Wounds were not always managed in line with people's care plans. Where people had wounds, they were not reviewed as required and pressure sore risk assessments were not reviewed when needed. One person's care plan stated they should have their dressings changed three times per week, but records showed they did not have their dressings changed for 20 days. We spoke to a staff member and the registered manager who told us dressings had run out so dressings had not been changed in line with the care plan. This placed them at significant risk of harm.
- Where people were known to become distressed, care plans and risk assessments failed to guide staff how to manage this risk. Records showed there had been a significant number of incidents where there had been abuse between people living at the home. This meant staff were not protecting people from harm.
- Staff were unclear how to manage risks to people's safety. We observed one staff member give incorrect information to an agency staff member about a person's modified diets and fluids. This lack of clear guidance for staff to enable them to support people safely placed people at significant risk of harm.

Risks to people were not managed and the provider failed to take action to mitigate risk to people. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems in place failed to protect people from abuse. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People were supported by staff who were not safely recruited. Gaps in people's employment history were

not always explored.
● One staff member had disclosed a criminal offence on their application form. Whilst this did not show in their Disclosure and Barring Service check, this was not explored, or risk assessed by the provider which may have placed people at risk. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● People were supported by a high number of agency staff who had not had adequate checks prior to commencing work. On the first day of inspection, five agency staff members were working at the home who had not worked there before. The registered manager told us they were different staff to those expected but no checks had been made with the recruitment agency to ensure they were competent and were able to meet people's needs safely.

The provider failed to ensure that recruitment checks were operated effectively to ensure they employed people of good character with the skills and competence to meet people's needs.
This was a breach of regulation 19(1) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff turnover was high and the agency staff supporting people was inconsistent. This meant they did not always know people well to be able to meet their needs safely.

Using medicines safely
● People's medicines were not administered safely. For example, one person was administered the incorrect dosage of insulin as their care plan had not been updated following a change to their prescription. This placed the person at risk of harm.
● People's medicines were not always stored safely. For example, one person's insulin was administered to them after it had been stored outside of the fridge for 7 weeks. The insulin box stated that the medicine should not be stored outside of the fridge for longer than 4 weeks. This meant the efficacy of the insulin may have been affected and placed this person at risk of harm.
● Fridge storage temperatures were not always in the safe range. Temperatures outside of this range had been recorded but no action had been taken to address this.
● Medicine stock counts were not always recorded on people's Medicine Administration Record (MAR) which meant that we could not be assured that medicines were being administered as prescribed.

The provider had failed to ensure that medicines were stored and administered safely. This placed people at harm. This was a breach of regulation 12(1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The home was not always clean and hygienic. One person told us, "I have only ever had 1 shower in here, the bathroom is too dirty so I refuse to go back in."
● Paint was chipping, doors were damaged and there was some rusting which would have made these areas difficult to clean and place people at risk of infection.
● The provider did not always ensure visitors were wearing Personal Protective Equipment (PPE) in line with current guidance. For example, we observed two maintenance workers wearing a face shield rather than a Type IIR face mask and a visiting relative was wearing a cloth face mask below their nose. This was also seen by the registered manager but was not addressed until we prompted them.
● Risks were not mitigated against the spread of infection. There was a sickness and diarrhoea outbreak on the first day of inspection. The registered manager was aware of this but no action had been taken to isolate

those who were symptomatic. We observed one person engaging in a group baking activity which may have resulted in cross contamination. This was brought to the attention of the nominated individual and symptomatic residents were immediately isolated and all baking products from the group baking activity were disposed of.

● Staff did not always comply with infection prevention and control guidance. We observed one staff member wearing a sweat band on their wrist and one staff member wearing a bracelet. This increased the risk of cross contamination and placed people at risk.

The home environment was not properly maintained, and hygiene standards were not maintained This placed people at risk of harm. This was a breach of regulation 15(1) (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

People were supported to have visitors in line with current guidance. However, there were no clear systems in place in respect to visiting. The registered manager told us there was a booking system in place and one visitor was expected. However, we observed multiple visitors attending the home who had not booked in. We observed a visitor in communal areas who was not wearing PPE in line with current guidance which may have placed people at risk. The registered manager saw this but failed to address it.

Learning lessons when things go wrong

● The provider did not learn lessons when things went wrong.

● The fire service had identified concerns around fire safety at a previous visit including where a fire escape gate in the garden was locked. We found no action had been taken and the garden gate was still locked at the time of inspection. This meant that people may not have been able to evacuate in the event of a fire and were at risk of harm.

● When things went wrong, little action was taken to review what went wrong and how to reduce the risk of reoccurrence. For example, one person's dressings ran out meaning their legs were not dressed in line with their care plan. The cause of this was not reviewed and no action was taken to ensure this did not happen again.

The provider had failed to take action to mitigate known risks. This placed people at harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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.

- People were unlawfully deprived of their liberty. One person's DoLS authorisation had expired and no application had been made to extend this. An application was made by the consultants during the inspection to address this.
- Where DoLS authorisations were in place, we found no evidence that mental capacity assessments had been completed to determine that people lacked capacity in the first instance. This meant that decisions were made on behalf of people with no legal authority.
- Consent to care and treatment and best interests' decisions were not always obtained in line with the MCA.
- Where people had bed rails on the beds, they had not always consented to this restriction and no mental capacity assessments had been completed to determine whether a best interests' decision was required and whether this was the least restrictive option available. This meant people were being unlawfully restricted.
- Decisions had been made in people's best interests to administer medicines covertly. Whilst this had been agreed by their GP, no mental capacity assessments had been completed to determine if people lacked capacity to decide on how medicines should be administered. This meant people may have been administered medicines covertly where they had capacity to make the decision independently.
- Staff did not always understand the principles of the MCA. For example, where one person had capacity to make their own decision regarding where they lived and had expressed a wish to return home, a staff member had recorded they didn't seem to understand they couldn't do so.

The provider had failed to ensure that people had consented to care and treatment and failed to undertake mental capacity assessments where required by the Mental Capacity Act 2005. These issues constituted a breach of regulation 11(1) (Need for Consent) 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 current needs were not fully assessed and did not always explore their diversity.
● People did not always have assessments of their needs in place and where they did, the quality of the information on file was inconsistent. Where external professionals such as Occupational Therapists and Speech and Language Therapists (SALT) had assessed people, their assessments were not always in people's care files. This meant we could not be assured how people's care needs had been assessed to ensure care was delivered in a way that met their assessed needs.
● Assessment documentation was duplicated and inconsistent which meant that staff did not always deliver care in line with people's needs.

Staff support: induction, training, skills and experience
● People were supported by staff who were not adequately trained to meet their needs. One staff member told us they had not received any training since they had started working at the home. Another staff member told us they had received no training since the start of the COVID-19 pandemic.
● The training matrix showed significant additional gaps where staff had received no up to date training including mandatory training such as safeguarding and fire safety.
● People were supported by staff who were not provided with supervision to ensure they were competent to meet people's needs.
● Agency staff working at the home did not have any induction even when they had not worked at the home before. This meant we could not be assured they were competent to meet people's needs.

The provider had failed to ensure staff were appropriately supported and adequately trained to meet people's needs. This was a breach of regulation 18(1) (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
● People had experienced unintended weight loss. Where they had experienced weight loss, no action had been taken to address this which placed people at risk of harm. Records showed that five people had been referred to dieticians due to unintended weight loss but this had not been identified until health professionals had visited the home due to concerns.
● People's nutritional and fluid intake records lacked detail and did not record what specific food people had eaten. This meant monitoring of nutritional intake was minimal and it was not identified where people were not eating or drinking sufficiently which placed them at risk of harm.
● People told us the food wasn't very good and they were not provided with alternative options if they didn't like it. One person told us, "The food is terrible and most of it you can't eat."
● People's dietary needs and preferences were not catered for. One person told us they were a vegetarian but they had been given a burnt meat sausage to eat.

The provider had failed to ensure that people were supported to eat food in line with their dietary requirements and had failed to take action where people had experienced unintended weight loss. This placed people at harm. This constituted a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not supported to access effective and timely care from other professionals. For example, where people had unintentionally lost weight, referrals weren't made for GP or dietician input.

● Where people needed SALT input, referrals had not been made. Where staff were unclear about people's diets in relation to whether they needed thickened fluids, no referral had been made to SALT to ensure the person was adequately assessed to ensure their needs were being met.

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

● People lived in a home that was not adapted to meet their needs. For example, minimal adaptions had been made to the home to support people living with dementia with orientation. Some bedroom doors were painted different colours but they had not been personalised to support people with orientation. Three bedroom doors had recently been replaced and didn't have room numbers on them and had not yet been painted. This would make it difficult for some people living with dementia to know where their room was.

● Corridors and communal areas were sparse and clinical in their appearance. There was little decoration to make the environment more homely.

● People's bedrooms were not always personalised to reflect their likes and preferences.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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 were not always spoken to in a caring and compassionate manner by staff. We observed one staff member telling a person to repeatedly sit. One person told us, "The staff can be horrible; they are unfriendly and rude and very impatient".
- People were not treated with respect. One person told us, "Often if there are two of them, they will talk over me in their own language and ignore me completely. I don't deserve to be treated like this".
- People's individual needs and differences were not recognised by the registered manager and staff and they were not treated in a personalised way. For example, it had been recorded that tablecloths could not be used at mealtimes as people living at the home would pull it off. This meant that people were being stigmatised as a person living with dementia rather than being treated in a way that respected their individual needs and rights.
- People were not supported by staff who engaged meaningfully with them. Where people were supported on a one to one basis, staff supported people in a task centred way and sat next to them or followed them round rather than engaging in activities or discussions that may be important to them.

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

- People were not listened to and supported to express their views regarding their own care. One person told us they felt like a prisoner at the home.
- People were not always given choice and care was provided to them rather than them being involved in their own care decisions. For example, we observed people being given meals without always being asked what they wanted.

Respecting and promoting people's privacy, dignity and independence

- People were supported by staff who did not always respect their dignity. We observed staff members supporting people to eat by standing up next to them whilst they were seated. This caused one staff member to drop a person's meal down their apron. This was not a dignified way of supporting people to eat.
- People's privacy was not always respected. For example, we observed staff changing a person's leg dressings with the door wide open and no screen to protect their dignity. This meant the person could be seen by anyone who walked through the corridor which was not dignified.
- People's confidentiality was not always respected. One person told us that a staff member discussed another person's skin integrity needs with them.
- People were not encouraged to be independent. One person told us, "I have not been outside for 2 years now, they won't let me out. I get no exercise". Where one person's mobility had been restricted and they

had been remaining in bed, they had not been encouraged to regain their independence.

The provider had failed to ensure that staff spoke to people with respect and treated them with dignity. These issues constituted a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 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

- Care plans were out of date and sometimes duplicated with current and old care plans which meant they did not provide clear guidance to staff regarding how to meet people's needs. This meant that people had received care that was not in line with their current care needs which may have placed them at risk of harm.
- People were not involved in planning their care and were not given choice and control over how their care was delivered.
- People did not receive personalised care that met their individual needs and care was delivered in a task centred way. One person told us, "I was made to eat breakfast in my room one day. I said I prefer to go in the lounge, but they didn't have time".
- People's care needs were not regularly reviewed and where they were, people or their relatives were not involved in the review process.

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 were not always supported in a way that complied with the Accessible Information Standard. One person had a hearing impairment and although their care plan guided staff how to communicate with them most effectively, we observed staff not following the care plan which caused the person to become distressed.
- People were not supported to communicate in a way that met their dementia needs. For example, we observed no evidence of any use of pictorial cue cards for people who had difficulty in interpreting verbal communication due to their dementia needs. This meant that decisions were made for them due to people's communication needs not being fully considered.

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 told us that staff did not engage with them and they felt isolated. One person told us, "Staff don't come and talk to me and I am very bored and frustrated". One staff member told us they didn't have time to do activities with people, so they just put music on or gave them games if an entertainer wasn't on.
- People were not always supported to follow their interests. One person told us they enjoyed sports and

had been watching a sporting event on the television in the communal lounge and just before the end result, the television was switched off by staff which really upset them.
● We observed some activities including baking and painting being undertaken during the inspection by an activities member of staff. However, this was not personalised to each person's individual interests.

Improving care quality in response to complaints or concerns
● A complaints policy was in place, but we found no evidence this was complied with. One complaint had been formally recorded in the last 12 months but this had not been addressed.
● Where concerns had been raised by external professionals, this was not always acted on.

End of life care and support
● People's end of life needs were not always discussed with them or their relatives. One relative told us it had been discussed on admission but when we reviewed other people's care files, there were no end of life wishes documented. The home's approach to end of life care and support was inconsistent.

The provider failed to ensure that people received a service that was person centred and reflected their personal preferences and individual needs. This was a breach of Regulation 9(1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. 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.

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

- The home was not well led. One person told us, "I don't think it is well run at all. The staff do as they like and obviously no-one stays as they are all agency".
- Leadership was weak and there was a lack of responsibility taken by the registered manager for overseeing the home. The provider did not have significant input in the running of the home and oversight was limited.
- Staff did not feel valued or supported which led to a poor culture amongst staff at the home. Staff told us that there was high staff turnover as their colleagues did not want to work there.
- There was a closed culture at the home. Institutionalised practices were in place that were disempowering to people and failed to promote good outcomes for them. People were not encouraged to be independent and systems were in place that restricted people without consideration of their individual needs. For example, people had been restricted by the unlawful use of bed rails and most people ate their meals in the communal lounge using an over the bed table.
- The provider had employed consultants to oversee the home, but they had only been at the home for 1-2 weeks at the time of our inspection. The consultants had identified a thorough action plan which they had started to work through. Their input was positive and focused on improving outcomes for people, but they had not been there long enough for significant changes to be seen at the time of inspection. The provider has given us assurances that the consultants will continue to provide daily support to the home and CQC will be notified in the event of their withdrawal from the home.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 and staff were unclear about their roles. One staff member told us, "We don't know who is doing what and we don't know who is in charge."
- The registered manager did not understand the need for quality performance and very few audits were in place to check the quality of the service. This meant that people were placed at risk as actions weren't identified to improve the quality of the service.
- Limited responsibility was taken for oversight of the home and quality checks. We discussed audits with the registered manager, and they told us they thought the clinical lead did medicines audits, but we did not see evidence of the audits undertaken by the clinical lead. This meant that medicine administration and recording errors had not been identified and continued to take place when action could have been taken to

reduce the risk of reoccurrence. The consultants completed a thorough medicines audit during the inspection.

● Systems in place to oversee staffing rotas did not ensure staff of the appropriate skill mix were deployed to each shift to meet people's needs. The registered manager told us it was a senior staff role to arrange staffing rotas, but no checks were in place to address where no senior staff had been put on the rota. This meant that checks allocated to senior permanent staff such as reviewing daily essential health monitoring records did not take place and placed people at risk of harm.

● Systems in place for the reporting of incidents and the management of risks were inconsistent. There was little oversight of risks to people living at the home and where staff identified risks to people, there was no clear process in place to address this. For example, where accidents and incident logs had been completed, there was no system in place for regular reviews by the registered manager. This meant that it was inconsistent where action had been taken and safeguarding referrals made which meant people remained at risk of harm.

● The registered manager was not open and honest with people when something went wrong. Relatives told us they only received feedback if they rung and asked the registered manager.

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

● The provider had not sought any feedback from people living at the home or their relatives. Where people did raise concerns or provide feedback, this was often disregarded and not taken seriously.

● The provider did not engage with staff to seek their feedback regarding the home. Team meetings did not take place to enable staff to raise any concerns or provide feedback for the improvement of the home.

Continuous learning and improving care

● Information to support performance monitoring was not available. There was no evidence of learning and development to improve care. Learning disseminated by other agencies was not shared with staff at the home.

● The registered manager did not understand the principles of good quality assurance and failed to take any action to ensure improvements were made.

Working in partnership with others

● The provider did not work in partnership with others. One professional told us it had been unusual as they had not received any referrals from the service for over six months.

● The provider failed to share information as required with other agencies. Where the provider was required to submit data regarding Covid-19, they had failed to do so for a number of months despite this being requested by CQC.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.