Qu'Appelle Residential Care Home Limited

Qu'Appelle 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:
Qu'Appelle Care Home is registered to provide accommodation and support for up to 36 older people, including people living with dementia. There were 25 people living in the home on the first day of our inspection.

People's experience of using this service:
The provider was still failing to provide people with consistently safe, effective, caring, responsive or well-led care.

The provider had failed to ensure sufficient staffing to care for people safely and to meet their needs in a timely way. Staff were using unsafe moving and handling techniques and the management of people's medicines was not consistently safe.

The provider had failed to ensure all staff had the necessary support and supervision to care for people in a consistently safe and effective way. Infection prevention and control practice was not consistently safe.

Staff continued to use undignified, impersonal language to refer to people living in the home and did not support people in a consistently compassionate and person-centred way. The provider had failed to respect people's right to privacy.

Care planning systems were not consistently effective and staff recruitment procedures required improvement. Systems of organisational governance were inadequate and the provider had failed to address all of the breaches of regulations identified at our last inspection.

In other areas, the provider was meeting people's needs.

Staff worked collaboratively with local health and social care services to ensure people had support when required. People received food and drink of their choice and their nutritional needs were met.

Staff worked in a non-discriminatory way and promoted people's independence. People felt safe living in the home and staff knew how to recognise and report any concerns to keep people safe from harm.

The provider upheld people's rights under the Mental Capacity Act 2005 and supported people to have maximum choice and control of their lives, in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice.

The registered manager had a candid, open leadership style and was liked and respected by his team. The provider notified the Care Quality Commission (CQC) and other organisations of issues as required.

There was learning from significant incidents and any complaints were managed in line with the provider's policy. People and their relatives were consulted on the running of the service.

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

Rating at last inspection and update:
The last rating for this service was Inadequate (published 16 May 2019) and there were multiple breaches of regulations. The service was placed in Special Measures. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Qu'Appelle Care Home on our website at www.cqc.org.uk.

We took enforcement action against the provider, including the urgent imposition of additional conditions of registration and the issuing of three fixed penalty notices. Some enforcement action is ongoing. 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.

At this inspection, we found insufficient improvement had been made and the provider was still in breach of regulations. The service remains in Special Measures.

Why we inspected:
This was a planned inspection based on the previous rating.

Enforcement:
We have identified five continuing breaches of regulations reflecting shortfalls in staffing, health and safety, respecting people's dignity and privacy, training and organisational governance.

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

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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 reponsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Qu'Appelle Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
Our inspection was conducted by an inspector, an assistant inspector and a specialist adviser whose specialism is nursing.

Service and service type:
Qu'Appelle Care Home 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 service had a manager registered with CQC. 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:
In planning our inspection, we reviewed information we had received about the service since the last inspection. This included information shared with us by other agencies and any notifications (events which happened in the service that the provider is required to tell us about).

During our inspection we spoke with five people to ask about their experience of the care provided. We also spoke with five family members, one of the cooks, four care staff, the registered manager and the quality assurance officer.

We reviewed a range of written records including six people's care plans, two staff recruitment files and

information relating to staff training and the auditing and monitoring of service provision.

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 Inadequate. At this inspection this key question has remained the same. This meant people were still not safe and were at risk of avoidable harm.

Staffing and recruitment
• At our last inspection in March 2019, we identified significant concerns with care staffing levels in the home, both during the day and at night. This was a breach of Regulation 18(1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the "2014 Regulations").
• Reflecting our concerns about night staffing, we imposed an urgent additional condition on the provider's registration, requiring the provider to, '… ensure a minimum of three staff members are deployed for the duration of every night shift … between the hours of 8.45pm and 7.45am'.
• At this inspection we found that there had been two occasions when the provider had failed to comply with this condition. The provider told us this was because a member of staff had unexpectedly failed to turn up for work. However, on both occasions this meant there were only two staff present for most of the night shift, to support and supervise at least 25 people, the majority of whom required 2:1 support with personal care.
• In respect of daytime staffing, the registered manager told us he had assessed the dependency levels of the people currently living in the home as requiring six staff on the 'early' shift and five on the 'late' shift. He told us this was the "absolute minimum" level of staffing necessary to support people safely.
• However, during our inspection, people, their relatives and staff told us both shifts were regularly short-staffed, leading to delays in attending to people's needs and a failure to supervise people safely at all times. For example, one person told us, "Sometimes you ring the bell and it's ages before they answer. I wait a long time. I am sure they are short of staff." A relative told us, "Sometimes I can sit in the [main lounge] and there is no member of staff [to supervise the people in the lounge]. I am always worried that someone is going to fall over. All these people in here and no staff. It does worry me. There should always be one member of staff at least." A staff member said, "Sometimes we don't have six on in the morning. People have to wait a bit longer."
• The registered manager confirmed that short-staffing was an issue, particularly on the late shift. Acknowledging one of the risks this presented to people's safety and welfare, he said, "There is no supervision [of people in the lounge] when we have four on [a late shift] instead of five."
• Analysis of the rotas in the week preceding our inspection indicated that almost 60% of late shifts ran, in whole or in part, with one staff member short. On one occasion, the late shift ran with only three staff from 18.20pm – 20.45pm. Discussing this incident, one staff member told us, "It's supposed to be a senior with four care assistants but sometimes it's only a senior plus two. It happened last week. [Name] was wandering. I had to leave the room [of another person] to sit [name] down. You can't leave someone to wander around [unsupervised]."
• The provider was still failing to ensure sufficient staffing to care for people safely and to meet their needs in a timely way. This was a continued breach of Regulation 18(1).
• At our last inspection, we found the provider's approach to staff recruitment was not consistently safe. At this inspection, we reviewed recent recruitment decisions and saw that (Disclosure and Barring Service) DBS

checks had been carried out to ensure staff were suitable to work with the people who lived in the home. However, recruitment files were still poorly maintained and there was no record of some references which had been obtained by telephone.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Using medicines safely

• At our last inspection we identified significant concerns with the provider's approach to assessing and mitigating risks to people's safety. This was a breach of Regulation 12 Safe care and treatment of the 2014 Regulations.
• At this inspection we found some improvements had been made. For example, the provider had implemented a range of measures to reduce the risk of people developing pressure ulcers. The environmental hazards we found at our last inspection had been addressed and the provider had also taken action to improve infection prevention and control procedures.
• However, not enough improvement had been made and the provider was still in breach of Regulation 12.
• There continued to be risks to people's safety and welfare. For example, we witnessed two separate occasions when staff used unsafe moving and handling techniques to lift people manually, without the use of a hoist. This increased the risk of harm to the two people involved.
• At lunchtime on the first day of our inspection, we saw two members of staff taking puddings to people who were eating lunch in their room. The puddings were uncovered, increasing the risk of cross-contamination and infection when they were carried through the home. Plate covers were available for use, but staff said they had been told not to use them for puddings.
• Some shortfalls also remained in the management of people's medicines. For example, the quality assurance officer told us that staff involved in the handling of medicines were aware of the requirement for two staff signatures when medicines were added manually to a person's medicine administration record (MAR). However, we found instances when medicines had been added to MARs without a second signature, increasing the risk of administration errors.
• The provider was still failing to support people in a consistently safe way. This was a continued breach of Regulation 12.

Systems and processes to safeguard people from the risk of abuse

• Since our last inspection, staff had received training in safeguarding procedures and were aware of how to report any concerns relating to people's welfare. Contact details for the local authority safeguarding team was included in the booklet people received when they first moved into the home.

Learning lessons when things go wrong

• Under the leadership of the registered manager, senior staff reviewed significant issues and events to identify organisational learning for the future. For instance, following a recent complaint, the registered manager had changed some procedures in the home to try to avoid something similar happening again. Describing his personal commitment to the development of an open, learning culture in the home, the registered manager told us, "[Staff] come up to ask me various questions. They are very comfortable talking to me. With me challenging their practice and them challenging mine."

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has improved to Requires Improvement. This meant the effectiveness and safety of some aspects of people's care and support was still inconsistent.

Staff support: induction, training, skills and experience
• At our last inspection, we found the provider had failed to ensure staff had the skills and knowledge to support people safely and effectively. This was a breach of Regulation 18(2) Staffing of the 2014 Regulations.
• At this inspection, we found the provider had made some improvements in the provision of staff training, supervision and support. For example, staff now received regular 1:1 supervision from the registered manager. They told us this was a helpful opportunity to reflect on their practice and discuss any training needs.
• We reviewed the provider's record of 'core' training and found that this was largely up to date. Commenting on the improvement in this area, one member of staff told us, "I've done loads of training [recently]. First aid, moving and handling, infection control. It's much, much better."
• However, not enough improvement had been made and the provider was still in breach of Regulation 18(2).
• Some staff did not always reflect the training they had received in their hands-on care practice. For example, as described in the Safe section of this report, staff who had received recent infection control and food hygiene training were seen carrying uncovered food through the home. Similarly, staff who had received recent moving and handling training were observed using unsafe lifting techniques.
• Staff told us, prior to our inspection, they had witnessed some of their colleagues using unsafe moving and handling techniques and had reported their concerns to senior staff. The registered manager acknowledged he was aware of at least one of these incidents. However, despite their awareness, senior staff had failed to adequately direct, supervise and support their staff to ensure their hands-on practice reflected the training they had received.
• The provider had failed to ensure all staff had the necessary support and supervision to care for people in a consistently safe and effective way. This was a continued breach of Regulation 18(2).

Supporting people to eat and drink enough to maintain a balanced diet
• At our last inspection, we found the provider had failed to ensure people's nutritional and hydration needs were properly met and monitored. This was a breach of Regulation 14 Meeting nutrition and hydration needs of the 2014 Regulations.
• At this inspection, enough improvement had been made and the provider was no longer in breach of Regulation 14. For example, systems were now in place to identify and support people who were at risk of weight loss. Additionally, changes had been made to the way staff were deployed to ensure people did not miss breakfast, an issue of concern we had identified at our last inspection.
• People told us they enjoyed the food and drink provided in the home and that their individual needs and

preferences were met. One person said, "The food is pretty good and if I ask for something different they'll get it." Another person said, "The cherry pie is good!"

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).
• At our last inspection, we found the provider had failed to obtain proper consent to care and treatment. This was a breach of Regulation 11 Need for consent of the 2014 Regulations.
• At this inspection, enough improvement had been made and the provider was no longer in breach of Regulation 11.
• We checked whether the service was working within the principles of the MCA, and were satisfied that appropriate legal authority had been obtained in situations where it was necessary to deprive people of their liberty.
• Additionally, the provider had recently initiated a 'MCA/Best Interests' review of people who had lost capacity to make significant decisions for themselves. Following this review, senior staff had started to use best interests decision-making processes to ensure proper consent to care and treatment had been obtained. Although further work was needed to complete the best interests review, where decisions had been taken, they were documented correctly in people's care records.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Systems were in place to assess and determine people's individual needs and preferences. These were set out in each person's care plan.
• The provider used a variety of online and other information sources to help staff keep up to date with changes to best practice guidance and legislation. For example, the registered manager attended local care home managers' forums which he told us was a source of helpful information for him and his team.

Staff working with other agencies to provide consistent, effective, timely care
• Senior staff had established good working relationships with a range of external organisations to support them in the provision of effective care and support. To further enhance communication with local healthcare providers, the registered manager told us he planned to apply for an NHS email address to enable people's confidential medical information to be shared securely when required.

Supporting people to live healthier lives, access healthcare services and support
• Staff worked proactively with GPs, district nurses and other health and social care professionals to ensure people had access to local health and social care services when necessary. One person told us, "[Staff] ring the GP and the district nurses if I want them." Another person said, "They take me to hospital, there's always someone comes with me. I am always worried at the hospital."
• Senior staff were in the process of updating the provider's approach to meeting people's oral care requirements. At the time of our inspection, oral care was included in each person's 'personal hygiene' care plan but the quality assurance officer told us she planned to introduce a new separate oral care section, to reduce the chance of this important issue being overlooked within each person's overall plan of care.

Adapting service, design, decoration to meet people's needs
• Since our last inspection, some bedrooms and communal areas had been repainted. The registered

manager told us this was part of an ongoing programme of redecoration. Looking ahead, he also said he was hoping to secure funding to create a new sensory garden to provide additional stimulation for people living with dementia.

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has improved to Requires Improvement. This meant people were still not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• At our last inspection in March 2019, we found the provider had failed to protect people's right to privacy and promote their dignity and respect. This was a breach of Regulation 10 Dignity and respect of the 2014 Regulations.
• Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 10.
• Staff continued to use the undignified and impersonal term 'feeds' to describe people who needed staff support to eat. One staff member told us, "We still use the phrase 'feeds' … between [ourselves]. For example, 'Who will do the feeds?'" Similarly, in an open lounge, we heard one member of staff tell a person, "I've got to feed you in a moment."
• In March 2019, we also found the 'treatment room' was often left unlocked and unattended. The treatment room was used to store people's care plans and other confidential personal information. On the first day of this inspection, we found the treatment room was still left unlocked and unattended at times. This meant anyone passing in the corridor could enter the room and access people's care plan documentation and other confidential information. Additionally, we found folders with people's personal information wedged behind handrails on open corridors.
• The provider's was still failing to treat people with dignity and respect and to uphold their right to privacy. This was a continued breach of Regulation 10.
• More positively, people told us that staff encouraged them to retain their independence for as long as possible. For example, one person said, "I wash my hands and face and arms. Staff do the places I can't reach." A staff member told us, "I try to help them keep their independence. I think it is important."

Ensuring people are well treated and supported; supporting people to express their views and be involved in making decisions about their care; respecting equality and diversity
• People told us that most staff were kind and caring and treated them in a person-centred way. For example, one person said, "The staff are very good. They'll do anything I ask them."
• However, during our inspection, we observed that staff were inconsistent in their approach and further action was required to ensure people were always supported with compassion in a fully person-centred way. For example, on the morning of first day of our inspection, staff who had provided one person with personal care had put the person's pyjama top on back to front and left them alone in their bedroom without a drink. Commenting on this incident, the registered manager said, "It depresses me. We have a handful of staff with attitudinal issues."
• More positively, people told us that staff encouraged them to express their views and retain control of day-

to-day decisions. For example, one person said, "I used to go downstairs for meals but now I prefer to eat in my room. Although, I am going downstairs later to have my hair done." Describing their approach, one staff member told us, "Every person is different. For instance, [name] is very set in her ways. She likes [her personal care] to be done the same way, every single day. It's their preference, what they want. No one is the same."

• Staff were aware of the importance of supporting people in a non-discriminatory way which reflected their beliefs and cultural preferences. For example, one person's religious belief about a particular medical intervention was highlighted prominently in their care plan.

• Senior staff were aware of local advocacy services and told us they would help people obtain this type of support if it was required or requested. Advocacy services are independent of the provider and the local authority and can support people to make and communicate their wishes.

Requires Improvement

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 Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant there was still inconsistencies in the planning and delivery of people's care.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• At our last inspection, we found significant shortfalls in the provider's approach to care planning. This contributed to a breach of Regulation 9 Person-centred care of the 2014 Regulations.
• At this inspection, we found enough improvement had been made in this area and the provider was no longer in breach of Regulation 9.
• Reflecting advice from the local authority, redesigned care planning documentation had been introduced and each person's care plan had been reviewed and updated using the new format. Commenting positively on the updated care plans, one staff member told us, "They are much, much better."
• The care plans we reviewed were generally well-organised and provided staff with information on people's wishes and requirements in a person-centred way. For example, the 'This is Me' section of one person's care plan stated, 'I like to get up between 9.00 and 9.30am. I do not require any assistance. I do not eat breakfast.' Another person's plan stated, 'I am C of E and like to take part in Holy Communion [services in the home] as I always used to go to church.'
• As described above, we were satisfied that the provider had made sufficient improvement to the care planning system to address this aspect of the breach of Regulation 9. However, further action was required to ensure every care plan provided staff with the information they needed to respond to people's needs safely and effectively at all times.
• For example, one person's diabetes care plan contained no instructions for staff on the action to be taken if the person showed signs of hypoglycaemia.
• Further action was also required to ensure all care plans were reviewed regularly. For example, there was no record that the monthly evaluation of one person's care plan had been completed since July 2019. Similarly, the registered manager acknowledged that action was still required to provide people and their families an opportunity to contribute to the care plan review process.

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
• At our last inspection, we found the provider had failed to provide people with sufficient physical and mental stimulation. This also contributed to a breach of Regulation 9.
• At this inspection, we found enough improvement had been made in this area and the provider was no longer in breach of Regulation 9.
• Since our last inspection, the provider had increased the size of the activities team. Two activities coordinators were now employed, working a total of 50 hours per week. Between them, the activities coordinators organised a programme of daily activities and events to provide people with physical and

mental stimulation. For November 2019, planned events included visits from a Salvation Army choir and a professional entertainer. Regular weekly activities included 'arts and crafts', 'music and movement' and quizzes.
• On the first day of our inspection we saw some people enjoying a game of dominoes together, whilst others completed a crossword. On the second day of our inspection, one of the activities coordinators facilitated a word game that was enjoyed by those who took part. Commenting positively on the activities provision in the home, one person told us, "A chap comes and plays the guitar, [we] make things and [one of the activities coordinators] does a quiz." A staff member said, "It's much better. [The activities coordinators] are brilliant. They have been doing pottery [recently] which is good for people's hands."
• The activities coordinators also spent 1:1 time with people who preferred to stay in their room, or who were being cared for in bed. One person who spent most of their time in their room told us, "They often come to chat to me. And people sometimes bring their dogs in to see me, which is nice."
• Looking ahead, the registered manager told us he was considering further initiatives in this area, including sourcing specialist training and support for the activities coordinators

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.
• The registered manager was aware of the AIS and had incorporated it into the provider's policy framework where necessary. Staff were aware of people's individual communication needs and preferences and reflected this in their practice. For example, in the way they communicated with one person with a visual impairment.

Improving care quality in response to complaints or concerns
• People and their relatives told us they knew how to raise any queries or concerns. For example, one person said, "If I am not happy, I can tell the carers or [one of the owners]. They are often here." However, the people we spoke with, told us they were generally satisfied and had no reason to complain. One person said, "As far as I'm concerned, things are really good."
• The registered manager maintained a record of any formal complaints that had been received and we saw that these had been investigated properly in accordance with the provider's policy.

End of life care and support
• No one living in the home at the time of our inspection was being provided with end of life care. However, the registered manager told us the staff team had experience of giving this type of care, should it be required in the future. To further enhance the knowledge of staff in this area, the registered manager told us he was looking into specialist end-of-life training.
• Most people's 'future wishes' for their end of life care were recorded in their care plan. The registered manager told us he was aware that this information still needed to be added to some people's care plans and this would be addressed as a priority.

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 Inadequate. At this inspection this key question has remained the same. This meant there were 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; 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
• At our last inspection we found the provider had failed to adequately assess, monitor and improve the quality of the service. This shortfall in organisational governance had resulted in significant risks to the safety and welfare of service users and was a breach of Regulation 17 Governance of the 2014 Regulations.
• At this inspection, we found the provider had made some improvements to the monitoring of service quality. Under the leadership of the quality assurance officer, a new system of daily, weekly and monthly audits and quality checks had been put in place. This had had a positive impact in addressing some of the shortfalls identified at our last inspection, for instance nutrition and hydration and pressure area care.
• However, eight months on from our last inspection, the process of service improvement was far from complete and the provider remained in breach of Regulation 17.
• As detailed throughout this report, we identified a number of continuing risks to service users' safety and welfare including short-staffing and the use of unsafe care practices. The provider remained in breach of four regulations and had also failed to comply fully with our additional condition of registration in respect of night staffing. Where breaches had been addressed, in some areas including care planning, further action was required to ensure the provision of a consistently safe, effective and responsive service.
• The new registered manager was well-liked and positively regarded by everyone we spoke with. One staff member told us, "[The registered manager] is a better manager than [the previous manager]. He's got more oomph to get things sorted." However, the registered manager acknowledged that much remained to be done, to ensure people received the safe, effective, caring and responsive service they were entitled to expect. Reflecting on his first few months in post, he told us, "I know we've got miles to go. I didn't think it would take so long."
• The registered manager also acknowledged that the care team lacked effective leadership, increasing the risks to people's safety and welfare. For example, as described in the Effective section of this report, senior staff were aware some members of the care team were using unsafe moving and handling practices but had not taken effective action to address this issue.
• Staff told us that the owners of the home visited regularly and took an active part in some aspects of the management the service. However, decision-making and lines of communication between the owners and the registered manager were sometimes confused which had a negative impact on the effective operation of the service. For example, the provider's nominated individual (who was also the owners' daughter) took the lead in preparing the staffing rotas. However, staff told us that these were often wrong. For instance,

insufficient staff were rostered on some shifts and staff were rostered for shifts they had already indicated they were unable to do. One staff member commented, "There's too many chiefs."
• The registered manager confirmed he had to personally amend the rotas before they were finalised, to ensure sufficient staff were rostered to meet the minimum staffing levels he had identified as being necessary to care for people safely and effectively. One member of staff told us, "I think [the registered provider] is trying to save money [by] doing the rota with less people on it."
• The provider's failure to take effective action to address all of the breaches of regulations identified at our last inspection and the other shortfalls in organisational governance described above, constituted a continued breach of Regulation 17.
• At our last inspection, we found the provider had failed to notify CQC of significant incidents and events in the home. This was a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009. The provider had also failed to ensure the proper display of the current CQC rating. This was a breach of Regulation 20A Requirement as to display of performance assessments of the 2014 Regulations.
• At this inspection, we found the provider had taken effective action to address both breaches.
• At our March 2019 inspection, we also found the provider had failed to appoint a person with the necessary competence, skills and experience to manage the home. This was a breach of Regulation 19 Fit and proper persons employed of the 2014 Regulations.
• Following that inspection, the provider appointed a former registered manager of the home as the new manager. In September 2019, his application to become the registered manager was accepted by CQC.
• Everyone we spoke with told us the new registered manager had made a positive impact since returning to the home. One staff member said, "I do think the home is well-managed. It's much, much better and that is down to [the registered manager]. He has got the morale up."
• Throughout our inspection, the registered manager displayed an exceptionally candid approach. He was also quick to acknowledge where further improvement was required. Describing his leadership style, the registered manager told us, "I have an open door and am accessible all the time. I will listen to anyone, on any subject at any time. I am learning all the time and I love it!"
• The registered manager's open, supportive approach set the cultural tone in the service and was appreciated and respected by his team. One staff member told us, "I think he is brilliant. He always says we [should go to him if we have any queries or suggestions]. So I go!" Another member of staff said, "It's much better since [the registered manager] came back. He listens." A relative told us, "In my opinion, the registered manager is competent. It's in his heart."
• Although, in his own words, he was "disappointed not to have achieved more", we were satisfied the registered manager had the necessary competence, skills and experience to manage the home and that the breach of Regulation 19 had been addressed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Continuous learning and improving care
• To promote people's involvement and engagement with the service, the provider organised regular meetings with people and their relatives. Commenting positively on the provider's approach, one relative told us, "They ask for suggestions and ask if everything's alright."
• As a further means of seeking people's feedback on the service, the quality assurance officer had recently started to distribute questionnaires to people, their relatives and other visitors to the home. We reviewed some of the completed questionnaires and noted one local healthcare professional had commented on how welcome staff had made them feel during visits to the home.
• The registered manager was committed to the ongoing improvement of the service in the future. For example, his plans to create a sensory garden and to source specialist training and support for the activities coordinators.
• Staff had established good relationships with a range of other organisations including local GPs and

nurses. Under the leadership of the quality assurance officer, the home was also participating in a pilot of a new approach to recording the administration of prescription creams.

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 provider's ongoing failure to treat people with dignity and respect and to uphold their right to privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider's continuing failure to support people in a consistently safe way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's failure to take effective action to address all of the breaches of regulations identified at our last inspection and other continuing shortfalls in organisational governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider's continuing failure to ensure sufficient staffing to care for people safely and to meet their needs in a timely way. The provider's continuing failure to ensure all staff had the necessary support and supervision to care for people in a consistently safe and effective way.