Alverstoke House Nursing Home

# Alverstoke House Nursing Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Alverstoke House Nursing Home is a care home providing accommodation and nursing care for up to 29 people, including people living with physical and nursing needs. There were 17 people living at the home at the time of the inspection.

People's experience of using this service and what we found
Significant concerns regarding infection prevention and control procedures were found. Practice was not in line with government guidance for care homes during the pandemic and placed people at risk of harm.

We continued to find for the third consecutive inspection that risks associated with people needs were not always assessed and plans implemented to mitigate these; Where people required specific intervention and monitoring to ensure risks associated with the needs were managed, guidance was not always consistent and records did not reflect people were receiving the support they needed to ensure their care was safe.

We continued to find for the third consecutive inspection medicines management was not safe. We could not be assured people were receiving the topical medicines they required and there was a lack of guidance to support staff to understand when this was needed. Protocols for 'as required' medicines were not consistently in place. A medicines error that placed a person at risk of harm had not been identified by the service.

Leadership and management of the service had been inconsistent and unstable and staff told us this resulted in a negative culture. Staff described a blame and bullying culture and a lack of confidence in the provider was expressed by some of them. The new manager was working hard to change this.

Despite receiving support from partner agencies since 2019 around monitoring of health conditions, medication management and care planning, the provider had been unable to demonstrate these areas had improved. The governance systems in place were ineffective in monitoring the safety and quality of the service and as such in driving improvements. The provider demonstrated a consistent failure to make and sustain improvements. They demonstrated a consistent failure to meet the requirements of the regulations. The ongoing failure of the provider meant people were placed at risk of receiving a poor quality and unsafe service.

We received mixed views about the staffing levels although we observed peoples request for support for responded to and call bells were not alarming for extended periods of time. We have made a recommendation about this.

Recruitment procedures were in place to help ensure staff were suitable for their role. Appropriate systems were in place to protect people from the risk of abuse and staff and the manager understood they role in safeguarding. The manager had started to take action to make improvements including; ensuring staff had

clear job descriptions, reinforcing registered nurses' accountability and revisiting their code of practice; identifying lead roles and sourcing training to support this. They had also recruited a project manager, who was looking at care plans and risk assessments.

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 requires improvement (Published 13 August 2020) and there was an ongoing breach of Regulation 12. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection to follow up on ongoing concerns we had received in relation to the safe care and treatment of people who lived in the service.

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 coronavirus and other infection outbreaks effectively.

This report only covers our findings in relation to the Safe and Well-led. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alverstoke House Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in relation to the management of risks associated with people's needs, infection prevention control, medicines management and governance systems.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning

information we may inspect sooner.

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 well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# Alverstoke House 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 Care Act 2014.

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.

Service and service type
Alverstoke House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been appointed and had started to work in the service from the beginning of December 2020. They had applied to become the registered manager. We refer to this person as the manager throughout the report.

Notice of inspection
We informed the provider we would be commencing inspection activity on 20/1/21. This was to ensure we

could receive the documents we wished to review before the site visit. We gave the service 30 minutes notice of our inspection site visit.

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 requested the manager and provider send us documents for us to review. This included care and medication records for 10 people, staff training records, policies and procedures, governance records and investigation records. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with four people who used the service. We spoke with three members of staff, the provider, the manager and deputy manager. People were not always able to speak with us in depth about the care they received so we spent time observing the support and interactions between people and staff. We also reviewed the environment and equipment in place.

After the inspection
We continued to seek clarification from the provider and manager to validate evidence found. We also spoke to a further seven 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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- We were not assured that the provider was admitting people safely to the service.
- The provider had recently admitted a person from the community to the service without following current national guidance. They had not ensured the person had been tested for COVID-19 before arriving at the home. They had not ensured an appropriate test for COVID-19 was undertaken on arrival to the home. They had not isolated this person or ensured that barrier nursing procedures were in place. The aim of barrier nursing is to protect staff against infection by people and protect people with highly infectious diseases from spreading it to others.
- We were somewhat assured that the provider was accessing testing for people using the service and staff. Weekly testing for staff was taking place and monthly testing for people living in the service. However, as the service had not followed national guidance about testing people on admission to the home, we could not be confident in their process.
- We were not assured that the provider was meeting shielding and social distancing rules. The service had a general risk assessment in place which did not reflect current national guidance for managing through the current pandemic. No individual risk assessments for service users had been undertaken to identify those people who may be at high risk if they contracted COVID -19 or at more risk of spreading the virus. As such no support measures for individuals had been identified.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service appeared clean, although some areas were cluttered with equipment. People told us; "Staff are always cleaning". Whilst regular cleaning was in place, we were not confident that this was sufficient in high risk areas, such as the visitor room and testing room because the records did not reflect regular cleaning especially of high touch points such as doors.
- We were not assured that the provider's infection prevention and control process were up to date to ensure that infection outbreaks could be effectively prevented or managed. The manager confirmed to us that they were not up to date with national guidance for infection control in care homes. The provider had not ensured the manager had received time or training to support them to gain the relevant knowledge. The provider had not identified a person to take responsibility for keeping the service policies and risk assessments up to date and accurate. National guidance states, 'It's important to assess residents twice daily for the development of a high temperature'. However, the provider and manager told us they expected staff to do this once a day but were unaware until we told them that the records they kept reflected this was not happening for people. This meant the service may not detect early signs of the virus in people and take action.

A failure to ensure risks associated with infection prevention control had been effectively assessed and appropriate, up to date and accurate plans were in place to prevent and manage any potential infection

outbreaks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections. Visitor to people were required to book in advance and to use a visiting POD. This was a small area created in the conservatory that allowed people to see their loved one with no direct physical risk from the pandemic. Where people were unwell and unable to use the pod a nominated relatives was able to visit them in their room. They were required to book in advance, they entered the home and were taken directly to a room closest to the entrance to be tested, to have their temperature checked and to ensure they had all the appropriate PPE. Once their test result was confirmed they negative they used the shortest and most direct route to the persons room.
● We were assured that the provider was using PPE effectively and safely. We observed staff wearing appropriate PP. However, some people told us staff would lower their masks when talking to them, if people could not hear them. They told us staff stepped back if this happened.

Assessing risk, safety monitoring and management
At our last two inspections we identified concerns with the management of risks to people in the home and found this to be in 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.

● At this inspection we found that some risks associated with people's needs had not been completed until we requested a copy of the risk assessment and care plan. This included risks associated with certain medicines and behaviours that posed risks to people and others. In addition, we found some areas of risk had not been assessed and plans to ensure appropriate support implemented. For example, we found that no one living at the home had been assessed regarding the level of risk to them from the current pandemic, COVID-19.
● At the last inspection we found that monitoring records did not provide us with assurances that people were supported as highlighted in their care plans and risk assessments or that these risks were monitored and managed as required. This concerns remained the same at this inspection. For example, for four people at risk of developing pressure sores we continued to find that monitoring provided no assurances that people had been supported to change their position as required by their care plan. In addition, conflicting guidance for staff about the frequency of repositioning for people was found in care plans, risk assessments, handover records and the repositioning records. This meant there was a risk to people not receiving safe care in relation to their pressure care needs as staff did not have clear guidance in place.
● At the last inspection we found that where people required support with their fluid intake, records did not reflect they were being provided with sufficient fluids. At this inspection this concern remained. The staff handover sheet contained information about people's target fluid intake in a 24-hour period. However, the monitoring records did not consistently reflect people were offered this amount of fluids over a 24-hour period. Where people were offered the target amount but did not consume this there was no evidence of any planned action to be taken.
● At the last inspection we could not be assured that people who suffered from specific medical conditions received effective monitoring of these conditions and that actions were taken in a timely way, when required. We continued to find this concern at this inspection. For example, one person's care plan stated their clinical observations, such as blood pressure and oxygen levels, should be checked routinely by staff, but we found that records stated these had not been checked since 7 November 2020. Clinical observations

such as blood pressure and oxygen levels are a vital part of the information gathering which helps to ensure safer care and early recognition of deterioration in people. We also found concerns for another person where their clinical observations were out of range for the person. Despite a staff having a discussion with the GP about the persons bowel movements, the records did not evidence the GP had been made aware of the clinical observations and there was no evidence staff had done any further clinical observations to recheck the person?. For one person we found staff needed to check their blood sugar was taken before their medicines was given, however, we found on 18 December 2020 there was no record confirming this had been done. The manager confirmed they had identified this but was unable to confidently say the blood sugars were checked. This was a concern as this had been raised as an area that needed improvement at our last inspection and by partner agencies in November 2020. Support had been provided by partner agencies. The manager told us they had reinforced staff responsibilities with them.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed, managed and mitigated is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt staff understood their needs and how to support them. Comments included; "Oh yes, they know how to look after me". One person told us how staff had responded following a fall. They described the staff as "excellent" and said the paramedic came very quickly. In discussion with staff they knew the needs of people and were able to tell us how they reduce some risks for them, such as falls. Falls risk assessments were in place and guided staff to risk reduction measures.
● Where people required equipment to manage risks associated with their needs, such as pressure relieving mattresses, we saw these were in place and that mattresses were set correctly, in line with people's weights.
● Following concerns regarding choking risks not being managed, the manager told us they had been working with the kitchen staff to ensure clear understanding of nutritional risks for people. Kitchen staff had access to information which highlighted these risks and how they were managed. Staff were aware of these risks and they were reflected in care plans. However, the handover sheet that staff used day to day was not completely accurate. The manager told us this would be updated.

Using medicines safely
At our last two inspections we identified concerns with the safe management of medicines in the home and have found this to be in 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.

● At out last inspection we found the information in relation to the frequency of cream application did not correspond with the signatures on the Topical Medicines Administration Records (TMAR) and information was conflicting.
● At this inspection we continued to find concerns regarding cream applications and TMAR. We looked at the records for five people in relation to topical medicines. We found guidance on the application of prescribed creams was not always consistent or clear. For example, for four people not all of the body maps in place provided guidance to staff about the frequency these creams should be applied. These body maps stated, "to be applied as needed", however, there was no guidance to indicate when they would be needed. Records were held which showed when creams had been applied, however, due to the lack of guidance about the frequency of application, we could not be assured this was being applied as required for the person. Where the frequency was recorded on body maps, the records did not reflect this was being

followed.
● We found some of these records suggested people had creams applied that they had not been prescribed. For example, records for one person showed staff had applied Epiderm but the medication administration record did not reflect this had been prescribed. Another person's records showed staff had applied double base gel, but the person was prescribed Zerobase cream.
● Some creams require risk assessment due to their paraffin content. We found one person was prescribed a cream which contained paraffin. The deputy manager confirmed that no risk assessment had been implemented. This meant the increased risk of fire associated with these creams had not been considered.
● Storage of medicines was not consistently safe. The temperature of central medicines storage areas was checked daily and maintained at safe levels. However, we found opened creams in people's rooms that were not stored away after use and left in people's rooms. Some of these creams had not been dated to show when they had been opened and in one person's room we found the label had worn off and as such this was no longer readable to confirm who it had been prescribed for.
● Protocols were not consistently in place for 'as required' medicines meaning staff did not always have access to guidance about the administration and monitoring of these medicines.
● Prior to the inspection we had been notified of a medicines error that occurred due to staff not ensuring stock was in the home. During the inspection we found the same concerns for another person, which the manager, deputy manager and provider had not identified. One person had been recommended to start a medicine on 26 November 2020. A request had been made to the GP to prescribe this. On 21 December 2020 the Older Person Mental Health (OPMH) team contacted the service to understand the effect this medicine was having on the person, but the medicine was not in the home. There was no evidence this was followed up by staff at the home. On 31 December 2020 the OPMH team called again. The medicine was still not in the home and at this point a member of staff followed it up with the GP. The medicines arrived on 4 January 2021 and staff began to administer this, however, the pharmacy had raised a query about whether they should take this new medicine with a current medicine already prescribed. Staff did not know they answer to this. They sought advice which they received four days later. Despite not knowing if both medicines should be given, staff continued to administer them both. The failure to ensure they had clear instructions about medicines administration before giving the medicines to the person placed the person at risk of harm.
● Since the last inspection an electronic medication system had been implemented. This system used a traffic light system to alert staff to which medicines are due to be administered and when. The system also alerted staff if a medicine had not been administered. The aim of the system was to reduce the likelihood of medicines errors in the home. Prior to the inspection we were notified of a medicines error, where the person did not receive their prescribed medicines because of an error on the electronic system that staff had failed to identify. We noted that the stock count of the electronic records and the physical stock count records by staff in the home did not always match and staff were not able to explain the reasons behind this.

The failure to ensure the safe management of medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they had no concerns about their medicines and received these when they needed them.

Learning lessons when things go wrong
● Partner agencies had been providing support to the service since 2019. Despite this support and our inspection findings, concerns identified at this inspection remained the same as we found at the last inspection. This demonstrated that the provider had not learnt lessons and made improvements when things went wrong.
● We were not assured that systems were effective in learning lessons when things went wrong. One

member of staff told us they were not aware of formal processes for reporting and escalating incidents or who was responsible for disseminating learning from incidents. A second member of staff said, "If things go wrong sometimes you hear it more through the grapevine. It is an area that could be improved on."

● The new manager was aware that this was an area that needed to be improved on. They had introduced a root cause analysis and reflective practice system when incidents occurred. They had also begun to analyse incidents and complaints in order to identify where lessons could be learnt.

Staffing and recruitment

● Recruitment procedures were in place to help ensure staff were suitable for their role. These included reference checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safe recruitment decisions. For nurses, checks were also conducted to ensure they were registered to practice.

● People and staff gave us mixed views about staffing levels. People felt they had to wait too long at times and said this was because staff told them they were too busy or that they were short staffed. Other people told us they felt there were plenty of staff. Staff comments reflected similar concerns to those of people, with some saying they felt rushed. Staff did inform us the manager was recruiting new staff and commented so hopefully we will have more time with them."

● We were aware of one person whom the manager told us needed one to one support due to their risk of falls but said this was not being provided because it was not funded for. We observed an incident where they were unsupported for a period of time because staff had not responded to their sensor alarm. They and the provider confirmed they hadn't considered redeployment of staff. We observed for the rest of our inspection visit a member of staff was always close by to this person. Following our inspection, the manager confirmed one to one support had been put in place for this person.

● The rotas reflected a consistent level of staff were provided and the manager told us this was based on people's needs. At the time of the inspection visit there were five care staff, one nurse, the manager, a training manager, the provider, kitchen staff, domestic staff and administration staff in the home.

● Generally, we observed there was enough staff to meet people's needs and we did not hear call bells alarming for extended periods of time and staff responded promptly to peoples requests.

We recommend the provider seek the views of people and staff regarding the staffing levels and response times in the service and take action to address their concerns.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living at the service. Comments included; "I feel very comfortable and safe."; "(staff) are always respectful, they always ask my permission";

● Staff were trained in safeguarding and the manager understood their responsibilities regarding safeguarding. Staff we spoke with understood their responsibilities to safeguard people and how to report their concerns. The manager had recently met with staff to reinforce to them safeguarding is everyone's responsibility and that they must report and refer concerns. To support this the manager had produced a written protocol for staff to follow.

● Where allegations of abuse had been made, we saw appropriate investigations had been completed by managers, in liaison with the local authority safeguarding team.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- The service has been rated requires improvement for the last three inspections. The service had been receiving support from partner agencies during this time to provide guidance on driving improvement within the home. This support focused on the areas of concern we had identified, including monitoring of health conditions, medication management and care planning. Despite this support, sufficient improvement had not been made. The provider has demonstrated a consistent failure to make and sustain improvements. They had demonstrated a consistent failure to meet the requirements of the regulations.
- The governance systems in place were ineffective. For example, we requested to see the services last care plan audits on 20 January 2021. The audits we did receive failed to identify the concerns we found on this inspection.
- Medicine audits had been ineffective and failed to identify actions to be taken. For example, we found the electronic audit identified a lack of stock but failed to record the reason behind this, or the action taken to prevent this from reoccurring. We reviewed another audit of actual medicine stock which identified discrepancies, but there was no explanation provided, and no action taken to prevent this from reoccurring. A further audit competed on 24 January 2021 was inaccurately completed. It asked if there were any issues at the last regulatory inspection and recorded the response as "no". However, the provider was in breach of Regulation 12 (the proper and safe management of medicines) at the last inspection. This inaccuracy meant the audit would fail to identify where regulatory action was required to address concerns.
- The clinical observation audit was a list of the latest observations taken. This audit failed to identify concerns and failed to identify any action or learning.
- Despite requiring staff to check people's temperatures every day, the audit failed to identify this was not happening.
- The wound audit completed on 26 January 2021 was ineffective because it was not accurate. For example, it asked how many people have wounds and recorded that no one had a wound however, it contained conflicting information and further in the audit identified two people with wounds.
- People told us they sometimes had to wait too long for their call bells to be answered. The provider had not audited staff response times to call bells because they said the system did not allow this. This meant they could not be assured that people's requests for support were being responded to promptly.
- The provider and manager had sent us their action plan prior to the inspection. On 16 December 2020 we advised the provider and manager that the action plan submitted did not confirm what they were doing to address concerns. We were sent a further action plan which did not cover all the areas of concern. We discussed this with the provider and manager. We received a further audit and action plan from the provider

on 4 January 2021. Within the audit the provider was assessing whether they were achieving the CQC ratings of "outstanding, good, requires improvement or inadequate" but the provider confirmed they had no guidance to sit alongside how this judgement was made. The provider told us they would put this in place, but this had not been done at the time of the inspection. The action plan remained unspecific in terms of the actions they intended to take to address the concerns.

The failure to ensure an effective governance system were in place and operated to assess, monitor and improve the safety and quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager was aware of their role and responsibilities, although they did confirm to us that they had not ensured they were up to date with national guidance regarding infection prevention and control.
● At this inspection we found the manager was open and transparent when we raised concerns found. They told us the service needed to make lots of significant improvements, nursing staff needed to take ownership and responsibility for their actions and for following up on issues of concern for people, in line with the code of professional conduct. They told us more structure and clear job roles were needed in the home. The manager told us they the service had no clinical competency framework in place for nursing staff. They said due to the number of new staff and recently qualified nurses this was vital and they had plans in place to develop this but recognised this would take time.
● The manager advised us of several actions they had taken to improve the service including; ensuring staff had clear job descriptions, reinforcing registered nurses' accountability and revisiting their code of practice; identifying lead roles and sourcing training to support this. They had also recruited a project manager, who was looking at care plans and risk assessments. They had also recruited a clinical lead, but that person was not due to start in post until August 2021.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Management and leadership in the service has been unstable and inconsistent. Staff told us this had resulted in a negative culture within the home.
● Staff told us of a blame, bullying and not feeling listened to culture in the service rather than one of support and learning. One told us, "There is conflict between staff, mainly because some of the staff aren't very welcoming to new staff. I don't know what the staff and owner do to address it, I know a staff member reported them on their leaving interview. I do believe that managers are now aware. I haven't said anything, I don't want to be picked on. I think I would be picked on if I said something, by the staff."
● A second member of staff told us, "Some of the staff are quite cliquey and not always very good with new members of staff. They expect new staff to know everything right away and don't want to support them. Staff were doing what they liked, some of the carers think they know more than what they do. Managers coming and going, staff did what they thought was right because there was a lack of guidance."
● One member of staff expressed a lack of confidence in the provider. They said, "There are so many changes in managers. The managers leave because [provider] doesn't know what [they are] talking about and covers things up. Years ago, that home had a really good reputation, [they have] run it into the ground. I genuinely care about the people there. You can tell things are in a bad way by the number of managers they go through."
● Staff expressed concerns with the number of changes in managers. One said, "There has been so many different managers and so many different ways, I don't think people could keep up with all the changes." A second said, "It needs a period of managerial stability. I think when they come to the job, they are not fully informed of what has gone on and the state of things."
● Despite this staff were hopeful that changes would be made as a result of the new manager starting. One

member of staff told us, "I think they have realised they need to make improvements, there have been a lot of things gone wrong recently. This manager seems hotter on everything." A second said, "[The manager] seems a lot more approachable. [The manager] will listen when you've got something to say. I think she is aware of the changes that need to be made."

● Five of nine staff were unable to tell us what the providers values were.

● People we spoke with told us they liked living at the home and felt they were well looked after. Comments included; "I'm happy here, the staff are good"; "The care is good"; "(Staff) always listen to me".

Working in partnership with others

● The local authorities quality team had recently become involved again and planned to support the new manager and provider to review and develop their governance systems.

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

● Staff told us they felt the new manager was open and honest and that this was improving since the new manager started. The manager had a good understand of their responsibility and there were processes in place to help ensure that if people came to harm, relevant people would be informed, in line with the duty of candour requirements.

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

● Staff meetings took place to enable staff to feedback. One member of staff when asked if they were encouraged to give feedback said, "I don't know about encouraged, but I say it anyway." They also told us, "I can't think of any changes as a result of something I've said. This is where people think what's the point of saying anything if they aren't going to do anything. It's like it's only a good idea if it comes from the top. Sometimes we have valid reasons for saying things and need to be listened to a bit more. Just because you are trained doesn't mean you know more than everybody else, we want to prevent things from happening, not deal with them after they have happened. I don't feel supported at the moment. We've had so many managers changes."

● Staff did tell us they felt this was changing with the new manager. They told us they felt the manager was listening and making changes based on their feedback.

● The manager told us they had not had time to hold any meetings with people who lived in the service, to seek their feedback but a resident newsletter was produced and given to people. They planned to start resident meetings in February 2021.

● The manager had very recently undertaken an audit of people and relatives' feedback, following surveys that had been sent out to them in January 2021. As a result of this audit they had implemented an action plan to address any concerns that had been raised. The actions included care plan reviews to be undertaken virtually, improved communication, care plan audits and resident meetings to be started.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The failure to ensure risks relating to the safety and welfare of people using the service are assessed, managed and mitigated is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>The failure to ensure the safe management of medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

We imposed conditions on the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | A failure to ensure risks associated with infection prevention control had been effectively assessed and appropriate, up to date and accurate plans were in place to prevent and manage any potential infection outbreaks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

We served a warning notice on the provider which required them to become compliant by 8 February 2021.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The failure to ensure an effective governance system was in place and operated to monitor the safety and quality of the service was a breach of Regulation 17 of the Health and Social Care Act |

2008 (Regulated Activities) Regulations 2014.

**The enforcement action we took:**

We imposed conditions on the providers registration.