Banstead, Carshalton And District Housing Society

Roseacre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Roseacre is a residential care home providing personal care for up to 40 older people, some of whom were living with dementia. The home is a large purpose-built care home run by Banstead, Carshalton and District Housing Society which is a Not for Profit Charitable Society. At the time of the inspection there were 24 people living at the service.

People's experience of using this service and what we found
People were not protected against risks associated with their care. The environment and equipment were not always clean or properly maintained. These concerns were raised at the last inspection and continued at this inspection. Staff were not confident in raising concerns around neglect and abuse and had not received appropriate training in safeguarding to ensure their knowledge in this area.

Although there were elements of good infection control practice, the systems in place to protect people from the COVID virus were not robust. People's medicines were not always being managed in a safe way. Accidents and incidents were not always recorded, and not enough action was taken to reduce further risks to people.

There were insufficient staff deployed to ensure that people received their care when needed. The registered manager and provider did not have appropriate systems in place to review people's dependency levels to ensure sufficient staff were on duty.

We observed instances of staff being kind and caring. However, people were not always treated with respect and dignity. The leadership at the service was not robust and there was a lack of auditing to review the quality of care. Staff did not always feel supported or valued. Notifications were not always being sent to the CQC where it was appropriate to do so. Relatives said communication was poor and people did not have opportunities to give their views about 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 Requires Improvement (published 13 January 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 5 December 2019. Breaches of legal requirements were found.

We undertook this focused inspection to check they had followed their action plan and to confirm they were now meeting legal requirements. This report only covers our findings in relation to the Key Questions Safe, Caring and Well Led which contain those requirements.

The inspection was also prompted in part by notification of an incident whereby a service user sustained a serious injury. The information CQC received about the incident indicated concerns about the management of falls. This inspection examined those risks.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. 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.

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

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 caring?

Requires Improvement

The service was not always caring

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.

Roseacre

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.

Due to concerns raised with us on the first day of inspection about the practices of staff we returned to the service for a second day.

Inspection team
Our inspection was completed by two inspectors.

Service and service type
Roseacre 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and health care professionals that work with the service. We used this information

to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with 14 members of staff including the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with one health care professional. We reviewed a range of records including five people's care records and medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and quality assurance records. We also spoke with five relatives and received feedback from two health care professionals.

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.

At our last inspection of the service, the provider had failed to ensure the environment, including the furniture, was well-maintained and fit for purpose. Areas of the building had been allowed to fall into a state of disrepair and equipment had not always been appropriately maintained. This was a breach of regulation 15 (Premises and Equipment) 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 15.

Assessing risk, safety monitoring and management;

- The premises and equipment at the service were not always maintained appropriately to keep people safe. The provider's infection control policy stated, "Any damaged equipment must be reported and repaired or condemned." However, the damaged fabric on the chairs, which was a concern at the last inspection, had not been addressed. This still left people at risk of getting an infection as the chairs they were sat on could not be cleaned appropriately.
- Staff told us they had to wait for equipment to be fixed, which impacted on their delivery of care. For example, the scales had been broken since June 2020, which meant people were not able to be weighed. A member of staff said, "Equipment doesn't get fixed quick enough." The service printer had not been working since May 2020 and updated risk assessments were not able to be printed off and placed in care plans. Staff at the service were only able to access the paper care plans so relied on that information to be printed and placed into the care plans. This was also raised as a concern by a visiting health care professional who told us the up to date information for people was not accessible to staff due to this being stored on the computer. One member of staff told us they were not always able to print and provide important health information to paramedics when they attended the service.
- One health care professional fed back that there were not sufficient air mattresses for people. They said, "I discussed alternating air mattresses in the home and the senior carer explained that they do not have enough air mattresses to facilitate all the residents' needs. Therefore, this leads to the mattresses being moved between residents dependent on who is highest priority."
- The lounge chairs people were sitting on were old and had lost their support. As such people were sitting low to the ground and struggled to stand up from them. We saw one person who was independently mobile getting up from the chair to go to the dining room. They struggled to stand and were heard saying, "I'm trying to get out (of the chair)." A health care professional told us, "The chairs are too low, and the same chairs are here from when I was working here years ago." Another told us, "I had mentioned the concern with the chairs last year."
- The walls and skirtings around the service were scuffed, chipped and wallpaper torn. A person said, "I think it could do with a bit of decorating." A relative said, "It's a bit scruffy, let's be honest." One member of

staff said, "It needs a lot of decorating. Just a bit of painting and rubbing down would make such a difference."

● The mobility equipment people were using was not always safe. One health care professional told us, "The wheelchairs are filthy and the foot plates swing." Footrests should be locked into position to prevent injury to people. There had been no health and safety checks of the environment or equipment for the provider to be assured that the environment was safe and equipment was clean and fit for purpose.

● Staff told us equipment was always running out and this caused stress having to ask the nominated individual to purchase more. One told us, "We run out of (continence) pads, wipes and toilet rolls." Staff told us at times they would bring in their own cleaning solutions and washing up liquid as the stock at the service had run out. We spoke with the nominated individual and the registered manager about this. As they did not undertake any audit of equipment and material at the service they acknowledged this may have been the case.

Failure to maintain the premises and equipment to a safe standard was a continued breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were not in place to ensure that people could alert staff when they needed help. Some people were unable to use the call bells due to their dementia. There had been no risk assessment around this or any evidence of how people were regularly checked and monitored if they could not summon staff. A member of staff told us that they would remind people with dementia to use the call bells despite them knowing people could not remember to do this.

● Care plans did not always contain up to date and relevant information concerning the risks associated with people's needs. One person's food consistency had been changed as they were at risk of choking. A member of staff told us, "I need to change her care plan back to soft as she spits her food out." Their care plan had not been updated since November 2019 where it stated that the person was on a "Normal diet." One member of staff told us they did not read people's risk assessments.

● People at the service had not been weighed since June 2020 due to the scales not working. One member of staff told us, "There are no food and fluid charts at present. We haven't been able to weigh people." After the inspection, the registered manager sent us evidence that people had been weighed. According to record eight people had lost weight since June 2020. One person's weight on 12 June 2020 was recorded as 94.90 and 74.15 on the 11 November 2020. Meaning they had lost over 20 kilograms over five months. Typed on the bottom of the weight chart it was recorded that two people were at 'high risk' of losing weight yet neither of them had been on a food and fluid chart to monitor that they were eating and drinking in sufficient amounts.

● One health care professional fed back they identified in November 2020 that there were two people who needed to be repositioned when sitting as they had, "Minimal independent body movements." However, neither person was being repositioned or had a pressure cushion to sit on to reduce the risks of developing a pressure sore.

Learning lessons when things go wrong

● Accident and incident records had very little detail on what preventative measures had been taken to reduce the likelihood of further occurrence. For example, in relation to people having falls. One incident form stating the person was found on the floor with the note stating the member surmised the person may have 'missed' the seat when going to sit on their chair. There was no additional information on how this may have occurred and how they supported the person. According to the incident reporting, the same person fell again five days later with the form just stating, "He was found on the floor."

● We noted that there had been 21 recorded unwitnessed falls at the service between 19 June 2020 and 9 November 2020. We asked the registered manager if incident and accident records were collated and

reviewed to look for trends and themes and they told us that they were not. This was a concern that had also been raised at the previous inspection. The registered manager acknowledged that they still had not taken action to address this.

● Where an injury had occurred, sufficient action was not always taken to protect people. For example, we were notified of an incident that resulted in a person fracturing their collar bone. The registered manager and nominated individual told us they believed it was a result of an unwitnessed fall on the stairs. The registered manager said, "We decided that the risk on the stairs was too great for people." However, action had not been taken to make the stairs safe until after another person fell and suffered the same injury. One member of staff told us, "We keep telling [person] not to use the stairs and [person] forgets." The risk assessments in the person's care plan did not contain any assessment on risks associated with accessing the stairs.

Using medicines safely

● Medicines were not being managed in a safe way. National Institute for Health and Care Excellence (NICE) guidance states that 'Care home providers must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as competent. Care home providers must ensure that staff who do not have the skills to administer medicines, despite completing the required training, are not allowed to administer medicines to residents.' In addition, the trained staff member administering medicines should follow the '6 R's' of Administration: Right Person, Right Medicine, Right Dose, Right Time, Right Route, Right to Refuse.

● The senior staff who were responsible for administering medicines were, at times, asking other untrained staff to give medicine to people in their rooms. The responsible staff member did not observe the medicines being taken and therefore could not be assured that the medicine was given to the correct person and that the person took their medicines as intended. We asked the member of staff doing this if that was the right thing to do. The member of staff said, "Probably not, no." Another staff member said they helped out the member of staff responsible for giving people their medication. When we asked the member of staff if they knew what the medicines were, they said, "I don't know what I'm giving." People were at risk from unsafe administration practices because at times this was delegated to untrained staff and the responsible staff member could not have effective oversight of the '6 R's' of Administration. This was despite the service medicine policy stating, "Medication should never be pre-dispensed or issued for another person to administer" and "Staff should only sign the MAR after the medicines have been taken and if this has been directly observed."

● Where people required 'as and when' medicines, there was not always guidance in place for staff on when this should be given. Where hand-written prescriptions had been entered on medicines administration records, these had not been signed by a member of staff or counter-signed. This contravened the provider's medicines policy, which stated that hand-written entries needed to be signed and, "The entry shall be witnessed by another person, who should also initial the entry."

● Staff told us they could not start administering medicines in the morning until they had completed personal care for people. One member of staff told us, "I would like to start meds sooner." They told us they did not have protected time when administering medicines and were frequently interrupted. They said this increased the risk of mistakes occurring. Some people were receiving time specific medicine; however, staff were not recording the exact time the person received this medicine. Therefore, the provider could not be assured that medicines were being given at the correct time to be effective and safe.

● We asked staff if they had been competency-assessed to administer medicine to people and they told us they had not. The registered manager confirmed that staff had not been competency-assessed around the administration of medicines. This meant the provider could not be assured that staff administered people's medicines safely.

● Some people had been prescribed medicine which increased the time taken for blood to clot. It is

measured by monitoring a patient's International Normalised Ratio (INR). We found that people's INR results were only received verbally and there was no recording of this or formal monitoring which put people at risk because staff may not be sure to administer the appropriate dosage of the medicine.

Preventing and controlling infection

● At the previous inspection there were concerns with the condition of some areas of the service that prevented effective infection prevention and control. This was due to chairs and other equipment being old and made of materials that were very difficult to clean. At this inspection we found parts of the home were clean and tidy however there were some aspects to the infection control practices that were not robust.

● We were not assured that the provider was preventing visitors from catching and spreading infections. Although visitors were asked to wear masks they were not asked for information about their current health. We found this when we visited on both dates. This was despite the service policy on visitors including, "Screening questions that our staff will ask a visitor on arrival are: 1. Have you been feeling unwell recently? and 2. Have you had recent onset of a new continuous cough?" When we arrived on the first day of inspection, we had our temperatures taken however this was not consistent. On the second day of the inspection our temperatures were not taken.

● We were not assured that the provider was always accessing testing for people using the service and staff. Two weeks prior to the inspection, arrangements had not been made by the registered manager to ensure that sufficient numbers of testing kits were available. That meant that staff were having to wait until these were ordered.

● We were not assured that staff were using Personal Protective Equipment effectively and safely. Throughout the second day of the inspection we frequently observed staff not wearing a mask whilst they were with people. Staff told us that there had been times when gloves and cleaning equipment had run out. One member of staff told us, "We ran out of gloves and we had to use marigolds until we managed to find a couple of boxes."

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. One relative said, "The cleanliness is very good. When you walk down the corridor it is always fresh, never a bad smell."

● We were assured that the provider's infection prevention and control policy was up to date.

The provider had failed to assess risks to people and to do all that was reasonably practical to mitigate risk. In addition, people's medicines were not always being managed in a safe way this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection of the service, we found the provider had not ensured there were sufficient staff deployed at the service to provide safe care to people. We made a recommendation about this. Enough improvement had not been made at this inspection and the provider was now in breach of regulation 18.

● People we spoke with fed back that staff were available to help them when they needed. One person said, "They come quickly when I press the call bell." Another said, "I take my turn, I know they are busy." A relative said of staff levels, "There are odd times when they've been a bit short." Another said, "Never enough staff but staff have been constant." A third told us, "There needs to be more staff in the lounge and more activities."

● At the previous inspection, we made recommendations to the provider to introduce a system to assess

people's needs to determine the number of staff needed on duty. At this inspection this had not changed and there was no tool being used to determine safe staffing levels. The registered manager told us they had intended to find a suitable tool to do this but had still not done this.

● Throughout the inspection, staff were busy supporting people but had little time to spend any meaningful time with them. People in their rooms were socially isolated as staff were not available to spend time with them. This was corroborated by staff and comments from them included, "We need more stimulation for people" and, "Everyone wants your attention at the same time, and we haven't got the time."

● There were six care staff on duty in the morning, two of whom were supporting seven people in the section that was designated for people living with dementia. This left four care staff to support 17 other people which staff told us was not enough as they felt people's needs had increased. We observed that most people living at the service required assistance from staff when moving. One member of staff said, "I would like more than four so the extra member of staff could make drinks and assist people with their meals." During lunch, we saw one member of staff supporting three people simultaneously at their table to eat their lunch.

● In addition to their essential care duties, care staff also had to allocate time to deliver activities and manage housekeeping tasks which added pressures on their time to support people. The registered manager told us, "We need one (an activity coordinator) but haven't got one now." The nominated individual said, "We have not been successful in recruiting." Although there was a 'head of care' working at the service to manage the home in the absence of the registered manager, they were often rostered as a carer which left little or no time for management duties. The member of staff told us, "I am 'on the floor' three days a per week and therefore find it difficult to keep on top of paperwork."

● Every day in the afternoon, the number of staff working on the residential unit reduced to three. On our second day of the inspection at the weekend a member of staff told us all three of them took their break at the same time when they had supported people to bed in the early evening. This meant that people on the ground and first floor were not being appropriately supervised. We asked the registered manager if they had undertaken a 'spot check' to the service in the evenings or at the weekend and they said they had not.

● There had been no staff recruited at the service since the last inspection, so we did not look at the recruitment practices. We asked the registered manager for four weeks of staff rotas prior to the date of the inspection. They only provided us with future rotas so we were unable to review what the staff levels had been.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe at the service. One person said, "I have never been neglected." A relative said, "I am happy they are safe and well looked-after; never had a reason to think otherwise." Another relative said, "The staff are consistent, and they seem very nice." A third told us, "[Family member] has been so safe. He would say if was worried."

● Despite these comments, we found that people were not being protected from the risk of neglect and abuse. Staff told us they did not feel confident in raising concerns with the registered manager or the nominated individual. One member of staff told us when they had a concern about staff conduct towards people, "There is no point in challenging anything as nothing gets done." Another member of staff told us, "If anything happens regarding abuse, we feel let down by management as they don't do anything." A third staff member told us that one staff member, "Can take things a little too far with residents." They described a member of staff joking with people about the virus and telling them that they have it.

● During the inspection we were made aware of an allegation of abuse that had occurred recently at the service. This related to a member of staff acting in an aggressive way towards a person. We reported this to the nominated individual who took immediate action. We also referred this to the local authority. Staff told

us they had either not had recent safeguarding training or had not received it at all. We asked the registered manager to provide us records of staff that had received safeguarding training. Despite a reminder, this was not provided

● We identified from an incident report a person had an unidentified bruise. This had not been raised as a safeguarding with the local authority or investigated by the registered manager at the service to determine the cause of the bruise.

Failure to protect people from the risk of abuse was a breach of regulation 13. of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported and did not always have choices around their care delivery.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● People and relatives told us that staff were caring. Comments from people included, "Staff are friendly", "They're very nice people here" and, "Staff are so helpful and kind." One relative told us, "The staff are absolutely excellent, they are friendly, and they care for the residents." Another said, "They (staff) are quite caring, he likes them and is happy."

● We saw instances of kind and caring interactions from staff, who interacted with people at eye level and supported them with their drinks. Despite this, people were not always treated in a dignified and respectful way. When we arrived at the service at 18.15 on a Sunday evening, we could see from outside, as the curtains were open, that people were sitting at the dining table with their night clothes on. We found that people were dressed into their night clothes early in the evening as a matter of routine rather than it being people's choice. A member of staff told us this was to manage the workload and, "If you don't do some before supper then you don't have time." Another member of staff told us, "People are just told they are getting in their pyjamas."

● One person's nightdress had pulled up above their waist when they were supported to sit at the dining table. A member of staff told us they had placed a blanket over the person's knees; however, the blanket kept falling off which exposed the person and compromised their dignity.

● Due to the shortage of staff, people did not always have a say in when they received their care. For example, staff told us people were only offered one bath or shower a week unless there was a specific need. One person told us, "We get a bath on certain days. I would like a bath more than once a week, but I wouldn't ask them (staff) as they are busy."

● One person told us they enjoyed talking to staff'. They told us they got lonely as, "I've got no friends to chat to." We asked a member of staff why the person could not stay in the lounge in the evening to talk to staff if they wanted to. The member of staff said, "He likes to talk, and stuff and we wouldn't be around to talk to him." The member of staff said of the person, "He knows he can get us to go to his room if he wants to talk."

● Chairs in the lounge were flush against each other giving no personal space for people. There was no space for people to place their personal items. Seating was not arranged in small clusters to encourage conversation.

● A member of staff told us that people's night clothes were laid on the floor in the communal bathroom. Another member of staff said, "Sometimes I line people's bed clothes on the floor, so nothing is forgotten." When asked if they thought this was dignified for people, the member of staff said, "It's not great. I wouldn't

want that if that was my mum."

Failure to treat people with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives and friends told us they were encouraged to visit and maintain relationships with people. One relative said, "If I see my (family member), then it used to be outside but is now inside in the TV lounge."
● People rooms were personalised with things that were important to them. One person said, "I enjoy spending time in my room."
● Staff told us that they liked working at the service. One said, "The residents are so lovely, they are like my family." Another said, "I really like it here. It's so rewarding."

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 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.

At the previous inspection there was a lack of leadership and systems and processes were not established and operated effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection there had not been sufficient improvement made and the provider remained in breach of regulation 17.

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

- At the previous inspection we identified that the auditing and governance was not robust which meant the quality of care was not reviewed appropriately. At this inspection we found this had not improved. We continued to find shortfalls that had not been picked up as no audits were taking place by the provider or registered manager.
- The registered manager was responsible for both Roseacre and another home of a similar size operated by the same provider. However, the majority of their time was spent at the other service. A person told us, "I haven't seen [registered manager] much." A relative told us, "(Registered manager) used to do (the head of care) job and I think (family member) misses her in that role and now she is manager and operates out of Roselands rather than Roseacre she doesn't see her as much."
- There were no systems in place to robustly check the quality of care. Staff training and, supervisions were not taking place, there had been no audit of the environment or care plans. This was raised as a concern at the previous inspection, yet steps had not been taken to address this. A member of staff said, "I report things to (registered manager) but nothing happens." The registered manager told us, "I would like some support in the office. I have no admin staff at all. I am trying to be everything."
- Following the inspection, we asked the registered manager to provide us with additional documents related to training records and any additional audits that took place. Despite reminding them this was not received.
- It is a requirement of the provider's registration that the most recent CQC rating is clearly displayed in the reception of the service and on the provider's website. However, on the day of the inspection there was no rating showing on the provider's website or in the reception of the service. This was despite the nominated individual being reminded by us in May 2020 to update their website with the correct rating.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider and registered manager had not created a culture where staff felt they could speak up about concerns around staff practice. Staff fed back to us there had been incidents when they were concerned about their colleagues' behaviour however, they were not confident action would be taken if they reported this.

● There was no system in place to gain people's views or to hear their feedback about the service. No meetings for people had taken place during 2020 and there had been no recent quality assurance surveys. One person said, "They haven't had any residents' meetings. I don't get asked about the food, if they did, I would be honest."

● Relatives did not always feel the communication from the service was good, particularly during the COVID pandemic. One relative told us, "Not had an awful lot of contact. No official communication since lockdown. Once or twice when I've instigated a phone call, been told residents and staff were tested and there's no cases." Another relative said, "I have been trying to get hold of (the nominated individual) for last six weeks and not been able to."

● Staff told us they did not feel there was strong leadership at the service. They felt the registered manager prioritised their work at the other service. One member of staff told us, "You don't very often see (the registered manager). If something comes up, by the time you see her the moment has passed." They did say however that the 'head of care' was, "Amazing and very supportive." A member of staff said that when the registered manager was in the service, "She will walk around a bit but there is no monitoring."

● Staff were not given an opportunity to attend meetings either as a group or at one-to-ones with the registered manager. One member of staff told us, "We feel let down by the management." Staff fed back they felt unsupported, stressed and not valued. One told us, "Everybody is stressed." Another said, "We felt neglected during lockdown. Just a phone call, a little letter, card saying 'I'm here for you' would have been nice."

● Health care professionals we spoke with said the provider or registered manager were not always engaged with working with them to help support people at the service. They told us they felt there was a lack of robust management structure at the service.

Failure to assess, monitor and improve the quality and safety of the services provided was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Since the last inspection we have had to frequently remind the provider to send in notifications where needed, for instance in relation to an extended period of absence of the registered manager.

● After the inspection we identified instances of safeguarding that should have been notified to the CQC, for example in relation to a person falling down the stairs and suffering an injury, but no steps had been taken to do this by the registered manager.

Failure to inform CQC of notifiable incidents was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.