Stilecroft (MPS) Limited

Stilecroft Residential 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
Stilecroft Residential Home (Stilecroft) is an older property that has been extended and adapted to provide personal care for up to 44 older adults and people living with dementia. There were 25 people the living at the home at the time of our inspection.

People's experience of using this service and what we found
We found shortfalls in the way the service was led. The provider's governance systems had failed to identify the issues we found on inspection. This included management of risk, maintaining a safe living environment, staffing levels not meeting people's needs, incomplete assessments, deficits in care planning, and not abiding to the requirements of the Mental Capacity Act. Auditing systems were not effective in monitoring and improving the service.

Risk was not always appropriately identified, assessed and managed in a timely manner. During the visit we identified several concerns regarding risk which were escalated to the registered provider who then took action. Safeguarding procedures aimed to keep people safe were not consistently implemented and when people had been exposed to risk of harm, incidents were not always reported to the local authority safeguarding team for review. Infection prevention control (IPC) measures were not robust with lapses in practice observed. People were receiving their medicines safely however the provider agreed to review how medicines were stored.

We made a recommendation the provider reviews IPC practices in the home.

Staffing levels, and the way staff were deployed did not always ensure people were safe and their needs were met. The oversight of people who required additional support to remain safe was inconsistent. We raised these issues with the provider who reviewed their staffing levels and very quickly arranged for additional extra staff hours.

People were not always supported by staff who had the training and skills to meet their needs. This was particularly the case when supporting people whose behaviours challenge the service, and those people living with dementia. Plans of care were not always reflective of people's needs and one person did not have a care plan or risk assessments in place for a high-risk need.

We made a recommendation about improving the support given to people living with dementia.

People's rights were not always protected by the actions of the service. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We saw people had been moved to different areas of the home without the appropriate best interests reviews and consultations.

We observed some positive interactions between staff and people who lived at the home. However, people did not always receive care in a timely way and that was personalised to meet their preferences and choices. Staff shortages, and the lack of an activity co-ordinator, had meant that people had limited support with their interests or to be engaged in meaningful activities. People told us they enjoyed the food and their dietary needs were monitored.

People told us staff were kind and caring. Relatives also praised the caring attitude of the staff team. They gave us positive feedback about how they were supported to maintain relationships across the pandemic and lockdown.

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

Rating at last inspection
The last rating for this service was good (published 24 April 2019).

Why we inspected
The inspection was prompted in part due to concerns received about infection control and leadership of the service. A decision was made for us to inspect and examine those risks.

We inspected and found there were further concerns, so we widened the scope of the inspection to become a comprehensive inspection which included all five key questions.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

The registered provider has been responsive to concerns noted during the inspection and has started to take action to make improvements and promote safety within the home. We were sent an action plan shortly after the inspection.

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 safe care and treatment, safeguarding service users from abuse and improper treatment, staffing, need for consent, person-centred care and good governance at this inspection.

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 request an action plan for the registered provider to understand what they will do to improve the standards of quality and safety. We will work alongside the registered provider and 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? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Stilecroft Residential 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 three inspectors, and an Expert by Experience. On days one and three, one inspector visited the home. On day two, two inspectors visited the home. One inspector reviewed evidence remotely throughout the site visit days. An Expert by Experience carried out telephone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Stilecroft 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 CQC, but this person had not worked for the provider for more than two years. A new manager was in post and was planning to register. This means that the provider and the registered manager are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the home had recently had an outbreak of COVID-19.

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, including social care professionals, community nurses and the infection prevention and control team.

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.

During the inspection
We spoke with the nominated individual, two representatives from the provider, the manager, three senior care assistants, four care assistants, the cook, head housekeeper, two domestic staff and two maintenance workers during the site visit. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the local fire and rescue, fire protection officer who was visiting the home to review systems and processes at the same time as our inspection.

We reviewed a range of care records. This included eight people's care records and medication records. We looked at two staff files in relation to recruitment, staff training and supervision. We examined the staff training matrix and staff rotas, and a variety of records relating to the management of the service, including policies and procedures, and environmental audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and care records. We spoke with 14 relatives and five more staff by telephone. We wrote to the provider to seek a response to immediate concerns about safety at the service. We liaised with the local authority, sharing concerns so that action could be taken, and the provider could be supported to make changes.

Inadequate

Is the service safe?

Our findings

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk was not always suitably monitored and addressed in a timely manner.
- During the inspection process we found risks associated with single pane glazing, window restrictors and portable appliance heating which had not been considered or addressed.
- We found some gaps in the management of fire safety. Staff had not completed any fire drills following changes to the layout of the home in February 2021.
- Care plans and risk assessments had not been updated to reflect the risks presented and how to mitigate risk for people who displayed behaviours which sometimes challenged the service. Staff told us they did not know how to intervene when people become aggressive towards another resident.
- Falls assessments had not been reviewed and updated in a timely manner. A person with a high risk of falls did not have risk assessments linked to care plans to instruct staff on how to keep them safe and reduce the risk of falls.
- Systems to ensure that lessons were learnt, and improvements made were not effectively implemented in the home. We found updated audits and schedules to improve the cleaning regime had not been implemented by staff.
- Information about safeguarding incidents were not shared with staff to encourage a lesson's learnt culture. Staff told us if they raised any concerns, they did not know what had been done about it. After serious incidents between people there were no team briefs to analyse and adapt staff approach to behaviours that may challenge.

We found no evidence that people had been harmed. However, the provider had failed to ensure effective risk management systems were in place for the safe delivery of care and a safe environment. Lessons were not being learnt. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, we wrote to the provider to seek assurance that immediate action would be taken. The provider responded immediately during and after the inspection. They confirmed, and sent evidence, that risks had been reviewed and measures were being developed to allow a more robust oversight of risk.

Systems and processes to safeguard people from the risk of abuse

- People were not always effectively safeguarded from potential abuse. Staff could tell us about safeguarding and what constituted abuse, but the provider's safeguarding policies and procedures were not always followed.
- The manager and staff had not identified incidents that should have been reported to safeguarding teams for investigation. This meant that management plans for people were not reviewed or updated and opportunities to prevent incidents reoccurring were missed.

The provider had failed to ensure systems and processes were established to effectively prevent abuse of service users. This was a breach of regulation 13 (Safeguarding service users from abuse and improper

treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People's needs were not being met by the current staffing levels.
● Observations made during the inspection and a review of specific incidents showed us that staffing levels did not allow current risk within the home to be suitably managed.
● Across all three visits we saw one staff member in a lounge supporting between six and eight people. At least one person in this lounge was assessed as needing two staff to support them on the first day of our visit, and another person required one to one support from staff. On the third visit we observed a domestic left to supervise this lounge while the care staff went to carry out a task. This person was not qualified or experienced for this role. We also observed people in this lounge who were left unattended, when the manager had told us a staff member must always be present to support people.
● Staff told us they were "run off their feet" and didn't have enough staff to see to everyone's needs in a timely way, or to keep people safe.
● People were not always supported in a timely way with their personal care needs. We observed a person ask for staff support to change an item of clothing to make them more comfortable while another person asked for support with personal care, both were told that staff would get to them when they could.
● The provider told us they used a staffing dependency tool to calculate staffing levels and provided us with assurances that they staffed above what was calculated within the tool. We reviewed the staffing dependency tool with two members of the management team and found that the service was not providing the hours calculated.

We found no evidence that people had been harmed however, the provider had failed to ensure there were always adequate numbers of suitably qualified staff on duty to deliver safe care and support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these issues with the provider who reviewed their staffing levels and very quickly arranged for additional extra staff hours.

● Recruitment had not taken place for some time but arrangements were in place for when staff recruitment recommenced. The provider had a Human Resources (HR) department to support managers with this process.

Preventing and controlling infection
● People were not always protected from the risk of infection as infection prevention control (IPC) measures as auditing was not robust.
● We observed lapses in IPC practice by staff that could put people at risk. For example, staff not wearing masks correctly and not following guidance on the correct disposal of personal protective equipment (PPE).
● The manager had received a considerable amount of support from local IPC experts. Advice from professionals was not always followed or acted on in a timely way to improve practice. Following the inspection visit, the provider gave us assurances that infection control processes had been strengthened and they were committed to ongoing work with the IPC team.

We made a recommendation about ensuing correct IPC practices were implemented and monitored according to the latest best practice.

Using medicines safely
● People were receiving their medicines safely and as prescribed.

● There were protocols for administering 'as and when required' medicines. We found these could be in more detail on what staff should do if these medicines were not effective.
● On the first day of inspection, the provider was temporarily storing medicines in the main office. We spoke with the manager about the risk and she moved them to a more secure area. The provider agreed to review the arrangements for appropriate storage of medicines.
● Senior staff had received medicines management training. The manager said she had started to monitor staff competence and was carrying out medicines' audits.

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 good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People needs were not always being thoroughly or accurately assessed and recorded, particularly when changes in people's health needs occurred. One person was found to have fallen and risk mitigation strategies were not looked into. Another person's notes recorded 'suicidal thoughts' with no further assessment of needs or support.
- Staff carrying out assessments did not have all the necessary training and checks for competence. Moving and handling assessments for people were being carried out by staff who had not received training for this role.
- The home was not following national best practice for the management of falls and dementia care.
- Staff did not always have clear care pathways to follow. New admissions of people to the home were not always well managed. The home's assessments were not sufficiently detailed. One person did not have an assessment until four days after admission. They were recorded as having diabetes but their care plans and assessments did not contain information about how this may affect them or guide staff in how to respond.
- The care planning system was electronic and not all staff had access to the system. Staff told us they had not read everyone's care plans.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people and include these in people's care and treatment assessments. This was breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was evidence of some partnership working with a range of health and social care professionals in people's care records.
- Referrals were not always made in a timely way for healthcare input. We asked that an issue with a person's skin integrity be referred to the community nursing team as the staff had not done this. The nursing team told us they had given training to staff in the home about the signs to look for with this particular skin condition and left untreated this condition could have serious consequences.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people and include these in people's care and treatment assessments. This was breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● People were not always supported by staff who had the right skills and knowledge.
● The delivery of training had been made much more difficult across the pandemic particularly as the home had a COVID-19 outbreak in early 2021. This had meant that some training areas only had 30% completion rates, such as in safeguarding adults from abuse. One staff member had been given a role as lead in IPC without any training or expectations of what the role entailed.
● Staff told us they needed more in-depth training on managing people who may display distressed reactions. Our observations supported this view. Some staff reported supporting people living with dementia with no training in this area, one staff said they had been working in the home for two years.

There was a failure to ensure that all staff had received appropriate support and training to enable them to carry out the duties. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the inspection training in moving and handling had re-commenced and the provider had a plan to ensure staff training was update. Safe use of PPE and infection control had also been delivered to small groups of staff by external IPC leads.

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

●The manager and staff did not always support people in line with principles of the MCA. People's capacity and consent was not always being assessed and recorded. This meant we could not be assured that DoLs application were correctly being applied.
● People had been moved from the dementia unit without the appropriate best interest process being followed and the local authority commissioning the care and adult social care had not been consulted. One relative of a person who lacks capacity told us, "They did change his room without telling us which I felt they shouldn't have."
● The use of a senor mat had not been considered as a restrictive practice requiring a best interest decision.
● We found that not all staff had received training in the MCA and its application, including the manager.

The provider had failed to ensure people were effectively supported in line with principles of the MCA and associated DoLS. This was a breach of Regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Stilecroft is an older property that had been adapted for its current use.
● The provider was currently reviewing how to best provide for people's needs across the whole home.

We recommend the provider review national good practice in the delivery of care to people living with dementia.

Supporting people to eat and drink enough to maintain a balanced diet

● People were generally well supported to maintain a balanced diet. Menus evidenced a choice of nutritional and balanced meals. A relative told us, "My relative says the food is brilliant." A number of relatives we spoke to were please that their relative had a healthy weight gain since arriving at the home.

● Information regarding people's nutrition and hydration needs was recorded in their care records on admission.

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 now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- All the of people living in the home that we spoke to told us the staff were "kind" and "caring" and they were satisfied with the care and services provided. They said they were coping with the lockdown measures and had been supported by staff to stay in touch with their relatives.
- Relatives we spoke to were also positive about the caring attitude of staff. One relative told us, "All the conversations I have with any staff always make me feel that they care about the residents." And another said, "When I speak to any member of staff they always speak kindly about (relative)."
- However, staffing levels meant people were not always treated in a dignified and person-centred manner. For example, people's dignity was sometimes compromised because staff could not always be suitably deployed in a timely manner. While we saw caring interactions between staff and residents there was little time for positive engagement with people apart from when a task was being carried out. When these tasks were being carried out staff spoke in a warm and friendly manner, using people's preferred name.
- Staff had attempted to support people to remain as independent as possible however, we found this was not always consistent.
- Visiting professionals, we spoke to said, that while staff always seemed very busy, they did observe warm interactions between staff and residents when they visited.
- When we spoke to the provider they assured us that an increase in staffing hours would allow more time for one to one interactions.

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

- Relatives we spoke to were generally happy with communications from the home. We saw in care notes that people and their relatives had been involved in drawing up care plans and asked for information about a person's life history, to help staff get to know people better.
- During the visit, we observed people making some day to day decisions. For example, choosing to stay in bed. These decisions were respected by staff at the time.
- Relatives expressed their gratitude on how the home had tried to keep them informed across the lockdown period when they could not visit. One relative told us, "They've tried hard to bridge the gap because we can't see our loved ones. Staff make sure the mobile phone is charged, and they let (relative) use their own phone for video chats. It's been very reassuring."

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive care that was personalised to meet their preferences and choices. We found not all care records accurately reflected people's individual needs. For example, when people sometimes displayed behaviours which challenged the service not all people had behaviour support plans to guide staff to manage the behaviours and reduce conflict for the person.
- While the majority of people did look well cared for, we did see some people who looked unkempt, wearing inappropriate clothing and no footwear. Care plans did not contain the level of detail and instruction about how to support people who maybe resistant to personal care.
- People had limited scope and support to engage in meaningful activities, and could be isolated in their rooms. Staff shortages, and the lack of an activity co-ordinator, had meant that people had not been supported with their interests or engaged in meaningful activities. We saw that people either spent most of their day watching TV, or spent time in their rooms.
- One staff member told us, "It's the quieter people I worry about. We try and pop our heads in to check and have a quick word. I'd love to spend more time with (person's name) as they've had a recent bereavement but sadly there's no time for that."
- Staff told us they tried their best to do activities but were really too busy to do many activities. One staff member said, "We try our best to do activities, but we are really too busy, sometimes we put music on."
- People had not had access to the outdoor space due to needing support from staff to be able to safely do this.

We found no evidence that people had come to harm however, people were at risk of not achieving positive outcomes. The provider failed to ensure people consistently received person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's life story, their interests and preferences had been sought and were being recorded in their care records. Relatives we spoke to told us that the home had made changes when they asked on behalf of their relatives, such as a preference for female carers, change in a bedtime and having fresh water first thing the morning.
- People and their relatives provided positive feedback about how they were supported to maintain relationships across the pandemic. The home had allocated an area for COVID safe visiting.

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.

● There was information in people's care plans about their communication needs and preferences. People had access to important documents in accessible formats.

End of life care and support

● People's end of life wishes, and needs were considered. Advanced care planning was in place for some people and this had been undertaken with family members. Visiting community nurse's and GP's had worked closely with the home to ensure that people who wished could remain in the home at the end of life.

● The home had set up safe procedures to enable family to visit people at the end of their life across the pandemic.

Improving care quality in response to complaints or concerns

● The service had a complaints policy in place. In the event people were not satisfied with the way in which their complaint had been handled, the service provided appropriate guidance on how to escalate concerns above home management level.

● Relative's told us that the home the new manager was "friendly" and "approachable" and they felt able to ask the staff any questions about concerns they may have.

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 shortfalls in the governance systems. 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

- The provider and the manager did not effectively have oversight on the delivery of care and safety of the environment in order to identify areas of improvement in a timely manner.
- The management and mitigation of risk was poorly managed which exposed people to harm.
- The provider's systems failed to identify the issues we found on inspection. This included management of risk, maintaining a safe living environment, staffing levels not meeting people's needs, incomplete assessments, deficits in care planning, and not abiding to the requirements of the Mental Capacity Act.
- Audits were either not completed or acted on to monitoring the quality and safety of the service and make improvements. Where the audits had identified concerns, the findings were not used in a prompt manner to address and improve the safety and quality of care. I
- Paperwork was not always in place, accurate and complete. Issues with the electronic care planning system had reported by staff had not been addressed. Staff told us this meant they did not always know people's current risk or needs.
- Updates to audits and cleaning regimes were not checked to ensure staff both knew about these updates and were abiding by them. We continued to find concern about the safe storage of hazardous substance, infection control processes and portage heaters on our further two visits. This placed people at risk.
- The manager had not demonstrated sufficient awareness of their roles and responsibilities. We found they had not always followed required standards, guidance and their own policies in various areas.
- The provider had submitted some statutory notifications to the Care Quality. However, we found a number of incidents of injuries that had not been notified and safeguarding concerns had not been shared with the local authority. This had not been picked up by the providers auditing processes. This will be looked at outside of the inspection process.

We found no evidence that people had been harmed however, systems were either not in place, followed or robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

- Systems for learning from incidents and near misses were in place but had not been adequately or consistently implemented. Accidents and incident reviewing systems and safeguarding processes were not robust.
- The manager and staff could not demonstrate whether they had reviewed what could be learnt from

significant events such as repeated falls or incidents of challenging behaviours.
● Tools to help mitigate risk were not in place to analyse falls to the individual and for trends across the home. This can help to identify patterns for a person if they fall repeatedly at night or at staff hand over, when observations may drop.
● Professionals visiting the home told us that relationships with professionals and communication within the home could be improved. Guidance provided by professionals had not always been followed. There continued to be failings in staff adhering to IPC measures, despite intensive input by an IPC nurse. We saw on inspection that staff were not challenged by the manager about these lapses.
● The provider did not always work effectively with others such as commissioners, safeguarding teams and health and other social care professionals. Safeguarding teams and commissioners were not always advised of notifiable events.

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
● Although we saw some positive and caring interactions, the culture within the service was not consistently person-centred and did not always achieve good outcomes for people.
● The provider's governance arrangements did not promote the provision of high-quality, person-centred care which fully protected people's human rights. One person's human right to a family life had not been considered and the principles of the MCA had not been applied for this person.
● Staff told us they didn't feel they were listened to and were not supported to speak up. Five staff we spoke to reported not being comfortable to raise issues with either the manager or the provider, as they had received a negative response in the past. The provider was aware of problems related to the culture in the home and the new manager was being supported to develop an open, inclusive culture.
● The provider had failed to act on recommendations made at the last two inspections to improve dementia care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was not ensuring policies and procedures around the duty of candour were being followed. A significant number of relatives told us that they were not informed about a COVID-19 outbreak in the home. One relative told us how she found out, "I ring every day to speak to (relative), but a carer answered instead and told me (relative) had tested positive for Covid, but had no symptoms, which was such a shock. The manager told me they didn't want to worry me, and I said that was fine if that was what she felt was right." Another relative told us they had heard from a neighbour about the outbreak in the home.
● Accidents and incident reviewing systems and safeguarding processes were not robust. We could not therefore be assured the duty of candour was consistently applied and the registered provider was open and honest when things had gone wrong.

We found no evidence that people had been harmed however, systems were either not in place, followed or robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection visit, we wrote to the provider to seek assurance that urgent action would be taken on the areas of risk identified. The provider took action to mitigate these areas of risk. They provided us with assurances that improvements would be made within the service. They told us additional help from senior managers would be provided to help the manager make the required improvements. We found the provider to be fully cooperative to working in partnership with us, and demonstrated they were keen to drive up

quality and safety within the service.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received consistent person-centred care. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people were effectively supported in line with principles of the MCA and associated DoLS. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health, safety and welfare of people. Systems were either not in place or robust enough to demonstrate safety was effectively managed. 12(1)(2)(a)(b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to protect people from abuse and improper treatment because safeguarding concerns had not been reported and systems and processes to investigate any allegations or evidence of such abuse were not robust. 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified and skilled staff were not always available to keep people safe. 18(1)(2)(a)

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems were in place and robust enough to keep people safe from the risk of harm and demonstrate the service was effectively managed. 17(1)(2)(a)(b)(c)(d)(f)

The enforcement action we took:

Warning notice issued