Premum Care Ltd

Serendipity Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Serendipity Home is a care home providing personal and nursing care to a maximum of 45 older people some of whom may be living with dementia and/or physical disability. At the time of the inspection the service was supporting 30 people.

People's experience of using this service and what we found
People at risk of harm were not always adequately protected. Risk management was poor, with risks not always being assessed or reviewed. Incidents were not always being recorded or reported appropriately. We made an urgent referral to the Greater Manchester Fire and Rescue Service (GMFRS) as we were concerned the homes fire risk assessment highlighted a number of outstanding works. We are currently liaising with GMFRS and the local authority to ensure these works are completed.

People who developed pressure ulcers or whose health needs changed were not always referred to health care professionals in a timely way. Staff were not always responsive to people's changing needs to ensure that the care and support they provided to people was personalised.

We found there were continuing, multiple and serious shortfalls significantly increasing the risk people would not receive safe care and treatment. Safeguarding incidents were not reported or investigated appropriately. The manager and staff did not recognise or respond to safeguarding incidents or follow established local procedures for reporting and investigating them.

The service was not well-led. There was insufficient risk management and quality monitoring. Statutory notifications were not always submitted when required. The registered provider and manager lacked an understanding around their regulatory requirements.

People did not always have access to enough staff to meet their care and support needs. People, their relatives and staff told us on many occasions that there was not enough staff to support people safely.

People living with dementia, did not always receive person centred care. There was a lack of meaningful and stimulating interactions with staff to occupy people's time.

The environment needed investment. We found areas within the home were tired and required decoration. We have also made a recommendation the provider reviews dementia friendly environments and consults current guidance, as we found aspects of the home lighting and patterned carpets did not support a dementia friendly environment.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We have made a recommendation about capacity assessments and best interest decisions.

People's medicines were managed safely, and the home had greatly benefitted from Trafford Council's medicines optimisation team with improvements to the medicines systems.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 27 February 2019) with breaches in regulations 12 (safe care and treatment) and 17 (good governance). We requested that an action plan needed to be completed, however this was not done by the provider. At this inspection improvement had not been made and the provider was still in breach of these and new regulations.

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

Enforcement
We have identified breaches in relation to person-centred care, safe care and treatment, dignity and respect, safeguarding service users from abuse and improper treatment, good governance, staffing and duty of candour.

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.

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

Follow up
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.

Special Measures
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 of 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.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our safe findings below.

Inadequate

Is the service caring?

The service was not caring.

Details are in our safe findings below.

Inadequate

Is the service responsive?

The service was not responsive.

Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our safe findings below.

Inadequate

Serendipity 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.

Inspection team
The inspection was carried out by two inspectors, one assistant inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was 'older people'.

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 used information we had received through our ongoing monitoring of the service and feedback we received from the local authority. Prior to our inspection we were informed by the local authority they had placed a voluntary embargo on any new admissions to the home, this was due to the local authority having concerns about the home. We used information the registered provider sent us in the Provider Information Return. This is information registered providers are required to send us with key information about their service, what they do well and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with 12 people and one person's relatives about their experience of the care provided. We spoke with eight members of staff including, the home manager, the deputy manager, one nurse, three care workers, the activities co-ordinator and the cook. We also spoke with two members of the external nursing team and a manager from Trafford Borough Council. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed records relating to the care people were receiving and the management of the service. This included, the medicine systems, six care plans, training and supervision records, audits, records of servicing and maintenance and a sample of policies and procedures.

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At the last inspection in January 2019 we found the provider had not taken reasonable steps to mitigate risks to the health and safety of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider was still not meeting the requirements of regulation 12.

- During the inspection we found the assessment and management of people's diets placed them at risk of choking or aspiration. For example, we identified two people had received the wrong level of thickeners in their modified drinks on several occasions.
- The provider failed to appropriately assess risks and was not taking reasonably practicable steps to mitigate such risk. We found one person had been observed recently by a staff member choking on food, therefore it was concerning the appropriate risk assessments were not in place to guide staff.
- People were at risk of developing pressure sores. Prior to our inspection we found one person had a significant breakdown in skin, this resulted in a pressure sore that became infected and was ungradable. We found the management teams monitoring of this person's skin care was inadequate, as they had missed opportunities to ensure this person received timely medical intervention.
- We found instances where two people who required two hourly re-positioning in their bed to reduce pressure on their skin had not been completed. On one occasion one person went over 10 hours without a re-position change. These shortfalls increased the likelihood people would develop sore skin and possibly pressure sores.
- Other risks to people were not managed to reduce the risk of harm. One person used a catheter. There was no guidance in place to help staff recognise and quickly respond to known risks such as the person developing a urinary tract infection. The system in place to monitor how much fluid the person had or monitor fluid they had passed was not followed or acted upon. This increased the risk of the person either receiving too little fluid and becoming dehydrated or not passing enough fluid which would require medical attention.
- People were placed at risk due as aspects of the environment had not being assessed. Prior to our inspection we became aware one person had accessed a security gate within the home that led to a stairwell, this person was found to have fallen. We found there was no lessons learned by the provider, we found the four security gates in the home were no longer fit for purpose as some were loose and did not have a locking mechanism in place. During our tour of the home we found an unlocked cluttered storage room on the first floor which posed as a potential trip hazard and vinyl gloves were left in a bathroom, which could be considered a potential choking risk if consumed.

● There were insufficient systems in place to ensure incidents were thoroughly investigated, reported, reviewed and monitored to prevent further occurrences. We found accidents and incidents had not always been reviewed and we highlighted two incidents that should have been reported as safeguarding concerns.

Failure to provide safe care and treatment by managing known risks to people was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Systems to safeguard people from abuse were poor and did not work effectively. Shortly before our inspection an allegation of abuse was raised by the ambulance service against the home. We found a person had not been safely supported after a fall, which placed them at further risk of injury. The provider dismissed a nurse who was on duty when this incident occurred, however we were not assured the manager and provider robustly investigated this safeguarding matter as appropriate action had not been taken against three other care workers who were also involved.

● A staff member disclosed to us an allegation of abuse they had witnessed by another staff member. We shared this information with the manager and provider and requested them to make an immediate safeguarding referral. However, a week after the incident we found this safeguarding concern had not been made.

● We found the manager and provider lacked understanding in how safeguarding matters should be reported and investigated. During the inspection we identified several safeguarding incidents that had not been reported when we reviewed accident and incident records. We raised an immediate safeguarding alert when we identified one person had unexplained bruising. There was also a near miss choking incident involving a staff member not preparing a drink correctly.

● Staff had received training about how to recognise allegations of abuse but did not demonstrate a clear understanding on how to respond or report safeguarding concerns to the relevant authorities.

This lack of robust provision to address allegations of abuse placed people at increased risk of harm. 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

● There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to keep people safe. A 'dependency tool' was used to help calculate how many nurses and care staff were needed. However, the dependency tool was poorly completed and did not fully consider how individual needs had been used to calculate the number of staff needed.

● People told us the home did not have enough staff on duty. Comments received from two people included, "They are short of staff. One of the staff should be here while you are talking to me, busy or not busy. No excuse" and "I think staff understand me and know what I am like…but they are short of staff… sometimes I have to wait to be taken to toilet. It can get uncomfortable."

● During the inspection we found a number of occasions when staff were not present in the lounge. On one occasion we intervened to move a table when we observed one person nearly tripping over a side table with their mobility aid.

● People told us they often had to wait too long to receive support from staff. During the two days of inspection we heard people's call bells constantly ringing out, which indicated there were not enough care staff available to meet people needs in a timely manner. On the second day we visited one person in their bedroom, as their call bell was ringing out. This person told us they needed to use the bathroom and said it was a "constant daily battle getting help." The service had no effective systems to monitor the frequency of

call bells to confirm when staff responded to them and the service was over reliant on their dependency tool to calculate whether staffing levels were adequate.

Failure to deploy sufficient care staff to promptly provide people with the care they needed and expected was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment records demonstrated the service was ensuring staff were subject to the appropriate scrutiny.

Using medicines safely
● We found people's medicines were safely managed. Prior to our inspection the service had received support from the local authorities' medicines optimisation team. This ensured medicines systems were organised, and people were receiving their medicines when they should. The provider was following safe protocols for the receipt, storage, administration and disposal of medicines.
● When people were prescribed medicines to take 'as required', there was guidance in place to support staff to know when this was needed. However, we found a small number of protocols were not in place, this was rectified during the inspection.

Preventing and controlling infection
● The home was clean and well presented. We observed housekeeping promptly attending to spills and cleaning up.
● Staff were seen washing their hands and using personal protective equipment when needed.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff were not always provided with sufficient training to enable them to support people safely. We requested the provider training matrix on numerous occasions throughout the inspection, this was not provided. We found the manager and providers oversight of training had lapsed and staff were not provided with training to understand the needs of the people they supported.
- Records showed new members of staff had received an introduction. However, records were not sufficiently detailed for us to determine which staff had then completed the refresher training the manager said was necessary.
- We viewed the training records for three staff, this indicated several e-learning training courses had been completed in a short space of time. We found one staff member had completed 15 courses over three days. This raised doubt of the ability for staff to retain this information.
- Some people developed pressure ulcers and as already stated in the safe section of this report the staff team had failed to request specialist support in a timely way, which meant one person developed an infected pressure sore. It was recommended by the safeguarding authority that the staff team complete training in this area. This training was only provided to staff after we raised this matter on inspection as to why it had not been completed in a timelier manner.
- The manager and provider failed to ensure the nursing staff working in the home were up to date with their training, to develop their skills further. The external nurse informed us they were in the process of developing a three-month plan in relation to staff training needs, clinical supervision, reflective practice and competencies. However, this plan was not in place due to them also waiting for the training matrix from the manager.
- The providers supervisions policy stated staff would receive a supervision every eight weeks as a minimum. However, we requested copies of staff supervisions on numerous occasions and these were not provided. When we spoke with staff they could not recall when they last had a supervision.

The provider and manager failed to ensure staff received adequate induction, training and supervision in their roles. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent effective, timely care

● The management team and provider had not always completed pre-admission assessments, taking in to consideration people's holistic information. At a recent safeguarding strategy meeting we were made aware the home had accepted a new person who was known to display behaviours that challenged others. This meeting raised concerns that the homes pre-assessment had failed to identify Serendipity Home was not the appropriate placement for this person.
● There were no effective systems in place to monitor and record people's food and fluid intake. We found one person was at risk of not drinking enough and could become dehydrated. We found inconsistencies in the fluids this person received. Staff did not know what the target amount set in their care plans was. This placed them at risk of dehydration.
● People's dietary needs were not always known to all staff. We found examples where staff had not provided the correct consistency when preparing drinks. A monitoring form was introduced three days before our inspection to ensure the staff team followed the correct procedure for each person.
● The service failed to make timely referrals to health and social care professionals when required. As noted in the safe section we found there had been a delay for one person's medical treatment after a fall and the service failed to seek specialist support in a timely way, which meant one person developed an infected pressure sore.
● During the inspection we spoke with one person who had been at the home since December 2019. They told us they were frustrated that they had not been able to get their toe nails clipped. We found this person's toe nails were long and no plans had been made to ensure this person was referred to a podiatrist.

Failure to provide safe care and treatment by managing known risks to people was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The chef had worked at the service for some time and was passionate about meeting people's nutritional needs. They were seen during the inspection asking people for meal choices. We found they had also sought people's feedback about the quality of the meals to ensure they adapted the menus to people's likes.

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.
● DoLS applications had been appropriately submitted to the local authority and were monitored to make sure they were adhered to.
● Capacity assessments and best interest decisions were made. They were not always decision specific and there was limited evidence of involvement from the person and significant others. There was no evidence that people had been unduly restricted.

We recommend the registered manager consider current guidance on assessing capacity and making best interest decisions.

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

● There had been a lack of investment for some time into the home. We found areas of the home were looking tired and would greatly benefit with a redecoration. One person's relative told us, "For what we pay every week, they could do with better furniture, like the armchairs for the residents."

● Over the past two inspections we found work had been completed to help people living with dementia and memory issues find their way around the home, with clear signage in place. However, we found there was a deterioration in signage at the home on our recent inspection, as some people's bedrooms did not have memory boxes or name plates to help people living with dementia find their bedrooms.

● During the last inspection the provider informed us they had plans to improve the lighting in the home and replace the patterned carpets in the two lounges, however we found this work had still not taken place. Patterned carpets can cause confusion for people living with dementia, as it becomes increasingly difficult to distinguish between design and actual objects that they need to pick up or step over. Areas of the home were not well lit including some of the corridors. Poor lighting will substantially reduce a person's ability to identify spaces, rooms, equipment and signs It can also contribute to accidents, particularly falls.

● People were supported to decorate their own bedrooms to meet their personal tastes. One person showed us their bedroom and told us they were happy to have been able to choose the decorations.

We recommend the provider reviews dementia-friendly environments and guidance to ensure the carpets and lighting within the home meets people's needs.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- There was not always a caring culture at the home, as people were not always supported in a caring way. Incidents where people had been subject to harm through poor care had not been adequately responded to and prevented where possible.
- People were not always treated with kindness and compassion by staff's approach, which was task focussed. Staff told us, they did not have enough time to spend with people throughout the day due to staff shortages. One staff member told us, "We don't have enough staff, not with five today, we were on six or seven and they [provider] have taken them off. It makes it really hard, you don't stop."
- The provider had equality and diversity policies and staff had received training in this area. However, it was not clear how staff respected and recognised people's diversity because staff did not always know people well and their approach to supporting people was task focussed.
- Wording in one person's care plan was not always respectful, it detailed they had a diagnosis of 'mental retardation'. This shows there was a lack of understanding and poor knowledge of the correct terminology to describe people who have a learning disability.

- We saw some positive interactions between people and staff. One staff member told us, "Never judge a book by its cover, always ask their permission before doing something, to just treat them as a human being." A relative told us, "[Person's name] is always looking happy, clean and in clean clothes."
- Staff told us they promoted people's privacy by respecting confidentiality and ensuring people were supported with discretion.
- One person told us, "I am treated well as a person. Staff made sure I have privacy."

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

- Some people were being involved with elements of their care planning. However, this was not consistently the case, for example people's risk assessments and their experiences at the home.

Inadequate

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 inadequate. This meant services were not planned or delivered in a way that met people's needs.

Support to follow interests and to take part in activities that are socially and culturally relevant to them; 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; Meeting people's communication needs

- People were not supported to engage in meaningful activities. During the inspection we found there was little social stimulation for people. People sat passively for a large part of the inspection, without input from staff. On the second day an activities coordinator attempted individual activities with board games and watching a movie. Some people were unable to voice their views, whilst others told us they were bored.
- In the lounges most people spent a lot of time sleeping in their armchairs due to no activities or staff interactions taking place. People who spent time in their rooms, as well as those who were living with dementia, were more reliant on staff to meet their needs. However, due to staff's workload and their task-focussed approach this meant people were at risk of social isolation.
- One member of staff told us, "The activities could be much better [activities coordinator's name] does their best, but they're also busy helping on the care side, so how can they be expected to put on meaningful activities."
- Staff had not always gathered information about people's life histories to provide a sense of who the person was and what they had enjoyed before moving into the home. Other people had information about their life, however, it was not evident how this was being used to provide meaningful and stimulating opportunities for people.
- Staff's knowledge of people's needs, and interests were basic. Often staff did not know about people's assessed needs and how to support them.

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.

- Care plans did not always include information on people's communication methods. Information was not always provided in a way that supported people to understand and make choices, particularly those living with dementia.
- People's communication needs were being identified in people's assessments. However, we found the service had made no efforts to ensure one person who had a learning disability fully understood their care plan, no consideration or attempts had been made to make this accessible for them.

This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

End of life care and support

● The home was providing support to people at the early stages of the end of their life at the time of inspection. Care plans had been developed for these people to give guidance to staff on how to support them.

● People's wishes for 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR') were highlighted within the care planning system.

Improving care quality in response to complaints or concerns

● The manager told us the home had not received any formal complaints since 2017. The complaint file we viewed was disorganised and in no particular order detailing historic complaints.

● People and their relatives told us they knew who to contact if they needed to raise a concern or make a complaint.

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
At the last inspection in January 2019 we found the provider had not established robust systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had not made the improvements needed and were still in breach of this regulation.

- The manager and registered provider did not have a good understanding of the requirements of their registration and lacked oversight of the service. We found the manager started in post in November 2019 and had still not attempted to register with the CQC.
- The registered provider repeatedly failed to deliver safe care and treatment or have robust oversight of the safety and quality of the service. This had led to continued and new breaches of regulation that should have been identified by effective quality assurance systems and action taken to address them.
- There was a lack of accountability and unclear responsibilities within the staff team which led to inconsistent and inaccurate record keeping.
- There was a lack of effective systems in place for quality monitoring and risk management, which led to errors and risks going unidentified and people being put at risk of not receiving adequate care and support to keep them safe.
- During the inspection we requested the homes fire risk assessment on several occasions, as a result of no fire risk assessment being provided, we made an urgent referral to the Greater Manchester Fire and Rescue Service (GMFRS). The manager provided the fire risk assessment five days after the inspection. This assessment identified several outstanding works that were required to be completed. We are currently liaising with GMFRS and the local authority to ensure these works are completed within the providers agreed timescales.
- At the last inspection we requested the provider complete an action plan detailing improvements the service was planning to make to meet the regulations. No action plan was submitted, this was a further indication there was a lack of governance and oversight at the home.
- There was no continuous learning and improving care at the home. Information and data collected by the manager was not analysed for any trends and patterns so actions could be taken to improve the service. We found a number of incidents that had not been reviewed by the manager, which would have indicated a safeguarding referral was needed.

Failure to assess, monitor and improve the service by completing robust quality checks and acting on feedback was a continuing breach of regulation 17 (Governance) 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

- Inadequate leadership and management identified at this inspection did not promote a positive and person-centred culture in the home.
- The provider's ineffective systems meant allegations of abuse were overlooked. This put people in their care at continued risk of harm and abuse. The provider failed to address this to prevent the safety of the service being further compromised, despite our prompts on inspection for manager to make a safeguarding referral.
- Changes to people's care needs were not always updated in their risk assessments and care plans to reflect current need and give guidance to staff.
- Staff did not receive consistent supervision and although the manager held regular staff meetings, we found the minutes of the meetings were task-focused and highlighted what staff hadn't done. This did not promote a culture of continuous learning to improve care and support.
- The provider had failed to create an empowering, open and person-centred culture. People were not consistently receiving a good service which meant good outcomes for people were not being achieved.
- People and their relatives were not fully engaged in the running of the service. People had limited opportunities to provide feedback as no surveys had been completed in 2019.
- Before our inspection, the local authority was visiting the service on a weekly basis and provided additional nursing support to assist the home. The local authority continued to engage with the provider during and after our inspection.
- Services providing health and social care to people are required to inform the CQC of important events happening in the service. This is so we can check appropriate action has been taken to keep people safe.
- Since the last inspection the registered provider had not submitted several notifications to the CQC in accordance with our guidelines. We are deciding our regulatory response to this and will publish our actions if made.

Failure to submit statutory notifications was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 manager did not fully understand the duty of candour. This requires the service to be honest with people, their representatives and others when things had not gone well. They did not fully know what types of events they had to tell stakeholders about and could not tell us what action they should take to give assurances things had been put right including offering an apology.
- We found the manager had not been honest when they reported a serious injury in respect of the conduct concerning three staff members, which meant no action about their conduct had been taken.