Maria Mallaband Limited

Troutbeck Care 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
Troutbeck Care Home is a nursing home providing personal and nursing care to up to 52 people. The service provides support to older people, some of whom were living with dementia. At the time of our inspection there were 38 people using the service.

People's experience of the service and what we found:

Staff delivered poor care and treatment to people, which put them at risk of significant harm. The service did not always properly assess and plan for risks, which meant measures were not in place to reduce or minimise them.

Staff were not always aware of people's care needs. This meant we could not be assured people were receiving appropriate care which was safe for them.

Staff did not support people to have enough to eat and drink. At the time of our inspection 20 people had suffered unintentional weight loss in the service at the time of our inspection. The service had not addressed this robustly to protect people from malnutrition and dehydration.

Staff did not take action, where safeguarding concerns were evident. They failed to protect people from incidents where people were repeatedly assaulted by another person using the service and had accepted this as the norm.

The building was not safely maintained, and the provider had failed to take prompt action to address fire safety concerns, which meant people were at risk of harm in the event of a fire.

People did not receive support from staff in a timely way and people made negative comments about the time it took for staff to respond to their needs.

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.

People's dignity and respect was compromised in the service and people were not provided with person centred care. There was a poor culture among the staff team at all levels, with some staff displaying a disregard for people's health and welfare.

People were at risk of social isolation, boredom and disengagement because the service did not ensure that they had sufficient sources of meaningful engagement or stimulation.

The provider has failed to operate the service in a way which is safe, effective, caring, responsive and well-led over a period of 9 years. The service has only been compliant with fundamental standards and regulations at one of 9 inspections since 2014.

Quality assurance systems had been ineffective in taking prompt action in response to shortfalls identified. This meant people had continued to receive poor care and be put at risk of harm.

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 Good (published 3 September 2019).

Why we inspected
The inspection was prompted in part due to concerns received about nutrition, sexual safety, wound care and staffing levels. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement and Recommendations
We have identified breaches in relation to person centred care, dignity and respect, consent to care and treatment, premises and equipment, safe care and treatment, nutrition and hydration, safeguarding, staffing and good governance.

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

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 from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Troutbeck Care 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 Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 3 inspectors, a pharmacist inspector and an 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.

Troutbeck Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Troutbeck Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was no registered manager in post. A new manager had started four weeks prior to the inspection and had plans to register with CQC.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We met with key stakeholders such as the local authority to fully understand their concerns and to include these in planning for our inspection.

During the inspection
Over the course of our three visits we reviewed the care records for 15 people. Multiple records relating to medicines and the management of the service were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
People were not protected from risks because the service had failed to identify or sufficiently plan for risks and guide staff on how to reduce and minimise these. This placed people at risk of significant harm.

The service failed to implement appropriate care planning for pressure area care and ensure staff were supporting people to reduce the risk of skin deterioration and integrity. Two people had developed red area's after not being properly repositioned.

The service failed to ensure that people were protected from the risks of choking, because staff were not always aware of these risks and they had not always been assessed and planned for. People at risk of choking or aspiration had received food of an unsafe consistency for them. This placed people at risk of choking.

The staff team did not act promptly on concerns about people's health, to ensure they received support to reduce the risk of becoming unwell or deterioration of their health. For example, on several occasions staff failed to take action where people did not have bowel movements for extended periods of time and could be at risk of constipation which could have significant impact on a person's health. Referrals had not been made to other external healthcare professionals where this would have been appropriate.

People living with dementia had access to substances or items which could cause harm to them. For example, tools were left in accessible areas and people had access to area's where substances such as cleaning products and flooring adhesive were present.

The above constitutes a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were poorly maintained in some areas. Risks in the environment, which could cause harm to people, had not been identified and acted upon. Multiple radiator covers had sharp edges which could cause skin tears. There were nails sticking out of the wall in one area and in some corridors, there were exposed hot water pipes which could cause burns.

The above constitutes a breach of Regulation 15: Premises and Equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse and avoidable harm

People using the service were not protected from the risk of abuse. Incidents involving another person who was living with dementia were happening frequently but had not been acted upon by staff or the management of the service until the council intervened.

People were not safeguarded from abuse and avoidable harm. Many people using the service had been identified as having unexplained injuries such as bruising or wounds which the service could not explain.

This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
The provider did not ensure there were sufficient numbers of staff deployed to ensure people received timely care. People told us they had to wait a long time for support, and this was confirmed by our observations. On the first two of our visits, staff were still getting people out of bed and giving them breakfast after 11am. There was an overlap between breakfast and lunch, because some people had not been supported out of bed until so late.

People were left for extended periods of time in communal areas with no staff present. Furthermore, there was no way to call for assistance if they needed help or if there was an emergency. On two occasions inspectors had to intervene to find staff to support people. One person was mobilising without their frame and was at risk of falling, no staff had been present or available to support them to remain safe.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider operated safe recruitment procedures.

Preventing and controlling infection
The care home was mostly clean throughout. However, the poor state of fixtures and fittings in some areas of the premises meant that effective cleaning was not possible. Staff were not always preventing the possible spread of infection. For example, hoist slings had been put together and were being sorted through on the floor of the service. This increased the risk of the spread of infection between people using the service.

Learning lessons when things go wrong
Whilst the service was rated good at the last inspection, the provider had not learnt from previous non-compliance. Systems and processes did not ensure that the quality of the service was maintained at a safe and effective level. This meant people had received inconsistent care for extended periods of time.

Incidents and accidents had not always been investigated and appropriate actions taken to reduce the risk of recurrence.

Using medicines safely
Medicines were stored securely and there was sufficient stock available to meet people's needs. Appropriate checks were in place to ensure medicines were fit for use.

Care plans were not always in place. Some people had medicines risk assessments completed but the care plan relating to the risk assessment was not always available.

TMARs (Topical Medicines Administration Records) were in place for those who required creams to be applied. However, these did not always give clear instructions to staff about where the cream was to be applied and staff did not always make a record of application.
The service had a process for the recording of thickener use. However, this was not completed daily or audited as part of the audit programme.

Recommendations

We recommend the provider reviews the policy and procedure for records relating to topical administration, and thickeners.

Visiting in Care Homes
People were able to receive visitors without restrictions in line with best practice guidance.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
People were not supported to eat and drink enough to maintain good health. At the time of our first visit, 15 people using the service had suffered 'unintentional weight loss'. By our third visit this had increased to 20 people who had suffered 'unintentional weight loss.' For example, one person weighed 23kg, which gave them a BMI of 10.31, making them very underweight. Despite this the service did not have any care planning in place about how the person was to be supported to gain weight. Nor were they monitoring their intake of food. After our first two visits, the service implemented a new care plan but at our third visit we found staff were not following it.

People and their relatives made negative comments about the food. One person said, "The food is diabolical. I have boxes of my own food because they don't come until dinner time to tell you what is on, and I don't always like it." Another person told us their friend brings them food because the food provided is poor quality. They said, "You can take or leave it, but the foods not so good." A relative said, "The food is atrocious it's a big issue."

The mealtime experience was not pleasant or well organised and there were insufficient staff available in the dining area to support people to eat their meal. There was an overlap between the breakfast and lunch time meal service. This could be confusing for those living with dementia.

Records did not demonstrate that people were supported to drink enough to maintain good hydration. During our visit we observed people without drinks or with drinks that were out of reach. Staff were not available in communal areas where people were present to offer them fluids. We had to find staff on one occasion after a person asked us for a drink.

We informed the provider of our concerns after the first two days of inspection. Following this, they deployed members of staff from their hospitality team to support existing staff to make improvements.

This was a breach of Regulation 14: Meeting nutrition and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support and staff working with other agencies to provide consistent, effective, timely care
The service did not work well with other agencies or external healthcare professionals. For example, staff

did not contact the GP for people who did not have a bowel movement for an extended period of time. Staff also failed to make referrals to dieticians or the Speech and Language Therapy Team (SALT) where this would have been appropriate. Advice given by healthcare professionals was not always followed.

This was a breach of Regulation 12: Safe Care and Treatment 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
People's needs were not always comprehensively assessed when they came to live at the service, or on an ongoing basis to monitor whether their needs were changing. Care plans did not reflect best practice guidance such as that provided by the National Institute of Health and Care Excellence (NICE) as they were too brief and did not instruct staff on how to care for people.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

The provider did not work in line with the Mental Capacity Act. People's capacity to make specific decisions was not always comprehensively assessed. Where people had been assessed as lacking capacity to make decisions, care planning did not always make clear what decisions they could make, such as choosing their food or clothing. Staff did not always give people opportunities to make decisions, such as what to eat and drink or where to spend their time. This meant we were not assured that the service was enabling people to make decisions based on their ability.

Deprivation of Liberty Safeguards (DoLS) applications had not always been made where these would be appropriate. This meant some people under constant supervision by staff and without the freedom to leave the building did not have the legal paperwork to support that this was in the person's best interests. Formal best interest's processes had not always been followed and staff had made decisions in people's best interests without following proper process.

This was a breach of Regulation 11: Consent to Care and Treatment of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Adapting service, design, decoration to meet people's needs
People's individual needs were not met by the adaption, design and decoration of the premises.
For example, many of the corridors were plain and white which made it harder to navigate around. There was nothing identifiable on many people's bedroom doors so they could identify their bedroom. There were no items of interest or stimulation for people to access independently as a source of engagement. People walked around the building in confusion and we had to intervene to help two people find their bedrooms.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
Staff had received training in subjects appropriate for the role but did not always demonstrate a good knowledge of subjects they had received training in. For example, all staff had received recent moving and handling training, but we observed staff mobilising someone in a wheelchair with no footplates on it. This placed them at risk of harm. Staff did not follow the principles of the Mental Capacity Act despite having received training in this subject. Staff practice had not been monitored and their competency assessed on a regular basis. This meant that shortfalls in training had not been identified.

Staff told us that they did not have regular supervision sessions. Records showed most staff had not had a supervision or appraisal this year. This meant we were not assured that staff were being supported to develop and improve in their role.

The service used new agency staff to supplement their staffing levels. These staff told us that they had not received an induction which included learning about the people they were providing care to. They told us they were supposed to be buddied up with a regular staff member but that this didn't always happen, and this confirmed our observations that new agency staff were working with people alone.

After our first two inspection visits we raised concerns with the provider about staff knowledge and training. They undertook an assessment of staff training and implemented additional training to improve knowledge.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity and respecting and promoting people's privacy, dignity and independence
The service was not caring. Whilst some staff were intuitively caring, the provider and management of the service had allowed people to be exposed to the risks of poor and inappropriate care.

There was a poor culture among the staff team in the service who ignored risks and normalised recurring risks and incidents, instead of acting upon them. This meant that one person had been subject to repeated safeguarding incidents that staff had come to accept as the norm.

The attitude of staff towards people's needs was poor and staff lacked empathy for people. One person was distressed about having not received personal care at 11:30am. They were lying in bed in a room with the curtains closed and no source of stimulation. They were wearing an inside out nightdress and had two flies on them, as well as having a 'sick bowl' filled with liquid next to them and two out of reach drinks. They rang their call bell and after 5 minutes, we went to find a staff member for them. A staff member was outside the door and had ignored their call for help. We asked for support for the person, and they commented, "The problem with [person] is that they want everything doing this second."

We were not assured that the provider and senior management of the service were caring. This is because they had failed to take action in response to the poor standards of care people were receiving. Audits carried out by the regional director showed that they were aware of the failing standards and concerns about staff practice, but prompt action was not taken to protect people from harm or to address shortfalls in staff practice.

After our first two days of inspection we raised our concerns with the provider who implemented a new senior management team which was in place at our third inspection visit. It was too early to assess whether this was effective in improving the quality of the service.

This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings, people and their relatives told us that in the main, staff treated them with kindness and care.

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

People were not always support to express their views and make decisions about their care.
Care records did not consistently reflect people's thoughts, feelings or wishes on their care. Care records were not person centred enough and did not reflect people as individuals.

There was not always evidence of people or their relative's involvement in care planning.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
People's privacy, dignity and independence were not respected and promoted.
Staff did not support people in a way that promoted their dignity. Some people had not been supported to dress appropriately. For example, people with inside out clothes on or a person with no shoes or socks. Another person had not been supported to be dressed on their bottom half, which meant their continence aids were visible. This did not promote their dignity.

There was a sign on one person's door informing staff they were blind, and that staff should announce their name on arrival. This did not promote the persons privacy because it meant anyone walking down the corridor, including visitors, were aware of their visual impairment.

We observed that staff did not always knock before entering people's bedrooms. We were in a bedroom speaking with someone when a staff member came in without first knocking. This did not promote people's right to privacy.

This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people's needs were not met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
People were not supported as individuals, in line with their needs and preferences.

Care records were not personalised to reflect people's diversity and individuality. Some preferences were included, but these were often limited and there was no information about people's routines or how they wished their care to be delivered.

Relatives told us that care was not always provided in line with people's preferences. One said, "My [relative] went into hospital knowing that they had not had a shower in ten days. I know they are short staffed but it's a matter of dignity."

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

The provider was not meeting the Accessible Information Standard.
People's communication needs were not understood and supported.

People's communication methods were not always recorded in their care records. Where people had limited verbal communication, there was no record of other ways they may communicate, such as with body language.

Information was not adapted to ensure people could access it. For example, food menus were in a small text which many older people may struggle to read. People living with dementia were not always supported to make visual choices. For example, they were not shown the food options they could choose from, nor were picture images available.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated

Activities) Regulated Activities.

End of life care and support
People were not supported at the end of their life to have a comfortable, dignified and pain free death.

Staff were unclear about who was at the end of their life and who was not. We were told one person was on end-of-life care, however, this was not correct. Discussions with staff indicated they did not have an understanding of when a person would be considered to be at the end of their life.

End of life care planning was not sufficiently detailed. For some people, no preferences were recorded. For other people who were in the end stages of their life. There was no information about the complex care they would require at this time to ensure they had a comfortable and pain free death.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities.

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 were not supported to maintain relationships, follow their interests or take part in activities that were relevant to them.

Over the course of our three visits people were largely disengaged and isolated, with little source of engagement or stimulation available. Care staff told us they did not have time to sit with people and engage with them, and this confirmed our observations.

We were told the service did have a member of activities staff. However, we did not see them present during our three visits. On one of our visits a local reverend came to speak with people. However, staff had not thought for how they could make this a pleasant experience for people. The television was playing loudly and so was some music, which made for a difficult environment in which to listen. It could also cause overstimulation for those living with dementia.

People who were cared for in bed or chose to stay in their bedrooms were socially isolated and were not supported to have sources of engagement in their bedroom. A relative told us the television remote for one person had been lost for some time so they were unable to watch television and were often just sitting in silence.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities.

Improving care quality in response to complaints or concerns
People's concerns and complaints were not always listened to, responded to and used to improve the quality of care.

Relatives told us they had made complaints which had not been responded to. However, this was from before the new manager had begun working for the service. Since the new manager came into post, we saw that they had been recording and responding to complaints.

We observed them visiting people whom they heard were unhappy to talk about the concerns face to face and see what action could be taken.

People were aware of who they could complain to and knew of the complaint's procedure.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

There was not a positive and open culture at the service. The provider did not have a system to provide person-centred care that achieved good outcomes for people.

Staff had developed a culture of ignoring shortfalls, poor care and safety issues which could put people at significant risk. Staff ignored people's requests for support and placed people in situations that put them at increased risk. For example, leaving people alone when they should be receiving one to one care. Staff repeated actions we saw them being told not to do because it put people at risk. For example, the manager told staff not to leave a cupboard unlocked because it contained items which could be dangerous to people. Staff left this open again shortly after being told not to.

Staff did not take action, where safeguarding concerns were evident. They failed to protect people from incidents where people were repeatedly assaulted by another person using the service and had accepted this as the norm.

People were not empowered and experienced poor outcomes which compromised their health and welfare.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements and continuous learning and improving care
A new manager had been in post for 4 weeks prior to our inspection. They had identified widespread shortfalls in the quality and had shared this with the senior leadership team. However, at the time of our visit the service was still unsafe, and people were at risk of harm as the provider had not taken sufficient action to address the shortfalls in the service and protect people.

The providers quality assurance system had identified shortfalls in the two months prior to our inspection,

but action had not been taken to follow up on these concerns robustly and ensure improvements were made. This meant people continued to receive poor care which placed them at risk of significant harm.

The manager told us that some audits carried out by staff had been completed inaccurately. For example, one audit stated that beds had been checked for safety defects. After the collapse of one bed, other beds were checked by a different staff member and safety defects were identified in three. Similarly, mattress audits carried out by one staff member stated there were no issues, but another audit carried out during one of our visits found that 18 mattresses required replacement. This meant we could not be assured that audits carried out at the service were robust or reflected an accurate picture.

Senior staff were not always honest with us at the inspection. One member of the senior leadership team provided us with the wrong documents to conceal safety issues they were aware of. The manager had been asked to conceal this information from us but decided to share it with us on our second day of visit as they wished to be open, honest and transparent.

The service has only been compliant with regulations and fundamental standards at 1 of 9 inspections carried out since 2014. There is a significant history of non-compliance and of failing to sustain improvements that are made. This means people have received inconsistent and poor care over an extended period of time.

The provider failed to have an effective governance system in place which supported them to continually learn, improve and embed change. Following feedback at this inspection, the provider had started to put an action plan in place to lead improvement.

People and their relatives made negative comments about the service. One person told us, "It's been traumatic, I have felt very vulnerable."

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
People and their relatives were given the opportunity to participate in a survey of their views and in meetings. However, people's feedback had not always been acted upon in a timely way. For example, there had been wide ranging complaints about the quality of the food provided over an extended period of time. Three people we spoke with were having food brought in by family members because they felt the quality of the food in the home was so poor.

Relatives told us they had not felt listened to by the service. One said, "Me and my brother are still waiting for a response about some issues we raised a while ago and this does not go down well with us."

After the first two days of inspection we raised concerns with the provider about the quality of the service. They told us they have since held meetings with relatives to gain their feedback and tell them how they intend to address the concerns.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

The provider did not always work in partnership with others.
Referrals were not always made to other professionals or organisations where this would have been appropriate.

Where advice had been provided by external healthcare professionals, this did not always lead to changes in care planning for people and care delivery.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users must— be appropriate, meet their needs, and reflect their preferences. But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users must be treated with dignity and respect. Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular—

ensuring the privacy of the service user;
supporting the autonomy, independence and involvement in the community of the service user;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment All premises and equipment used by the service provider must be— clean, secure, suitable for the purpose for which they are being used, properly used properly maintained