First For Care Limited

Butterley House

Inspection report

Coach Road
Butterley
Ripley
Derbyshire
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Tel: 01773745636

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

Summary of findings

Overall summary

About the service
Butterley House is a residential care home providing personal care to 33 people aged 65 and over at the time of the inspection. The service can support up to 37 people.

The accommodation is provided over two floors. The upper floor has bedrooms toileting and bathing facilities. The downstairs also has bedrooms and toilet and bathing facilities with the addition of two large communal spaces, a conservatory and a dining space. The garden was well maintained and provided an accessible space which was safe for people to use.

People's experience of using this service and what we found

The governance of the home was insufficient to ensure that people received support to keep them safe and maintain their wellbeing. Audits had not always been completed or used to develop improvements. Partnerships had not always been developed to enhance the care available to support people and the staff. There was no current manager and the provider had invested in consultants to support the daily running of the home. However, they did not always know the people's needs or manage the staff to ensure care was received in a timely way.

Staff and relatives had not been kept informed about the governance or changes to the home and people had not been consulted on their care needs We had not always been notified of events or the provider had not recognised when some incidents should have been raised as a safeguard.

Medicine management was not in accordance with national guidance and people were not always protected from the risk of harm or infection. Staff had been recruited, however not all the required checks had been completed consistently. There were sufficient staff to provide people's care, however they were not always deployed to ensure these needs were met.

Bedrooms and communal spaces were cluttered, untidy and not always cleaned to the required standards. People did not always had access to a call bell to request support when needed.

People had a choice of meal, although they had not been consulted on the menu. Information about people's dietary needs had not been shared and this placed people at risk of receiving a meal unsuitable for their needs which may place them at risk of choking.

People's choice about their care needs had not been considered or supported. They had not been consulted on how they wished to spend their day and encouraged to follow their interests or hobbies.

Care plans were not consistent and some had not been reviewed since July 2019. Staff had not got access to

the care plans and the information they required to provide people with their current needs. When people required support with their health care this was available, however the guidance provided was not always followed.

We have made a recommendation the provider should consider the national guidance on the environment for people living with dementia, recruitment and to review the support they provide for people in relation to people's capacity.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service didn't always supported this practice.

There was a complaints policy, however any received had not been recorded in accordance with this. There was mixed feelings about the culture of the home. Some people told us they had established positive relationships with the staff. The environment was not always suitable; however, the provider had made some improvements and was investing in further aspects of the home to ensure it was safe and welcoming.

The provider had displayed the previous rating.

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

Rating at last inspection (28 May 2018) –
The last rating for this service was Good. This was under the previous provider. This was the new provider's first inspection since their registration with us on 29 January 2019.

Why we inspected
The inspection was prompted in part due to concerns received about infection control, staffing levels and safe care and treatment of people. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements in all areas of the domains we report on.

Enforcement
We have identified six breaches in relation to people's dignity, safety, person centred care, staff training and the oversight of the home at this inspection.

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
Immediately after our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report . In response, the provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk. Additional resources were also immediately deployed to the service. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received 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 of 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?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always 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.

Butterley House

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
Two inspectors 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
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Service and service type
Butterley House 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 didn't have a registered manager. In the absence of their registration, the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The provider had recruited a new manager who was completing their recruitment checks. In the interim the provider had consultants supporting the home on a day to day basis.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report. We liaised with the local authority and the local health care practitioners. We used all of this information to plan our inspection.

During the inspection-
We spoke with seven people who used the service and three relatives about their experience of the care provided. We spoke with eight members of staff these included, care staff, senior care staff, domestic staff, the cook, the provider, three consultants and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with two health care professionals during the inspection. `

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 under the previous owners this key question was rated as Good. This is the first inspection at this location for this provider and this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

●People were not protected from the risk of harm. We found several people had bruises or skin tears which were unexplained. No investigation had taken place or referrals made to the local authority to reflect concerns. A relative told us, "[Name] has lots of bruises on their arm, they have a plaster on their arm and we don't know what it's from."

● People and relatives, we spoke with felt that safety measures were not always in place. One person said, "I feel safe up to a point, but people do wander around particularly at night and when I am in bed and come into my room, it's not nice." Another person also reflected this concern, "I have my own room though sometimes people wander in." There was no system in place to ensure people felt safe from harm during the night.

● The provider responded immediately after the first day of the inspection to put in a system to rectify these concerns. However, on the second day of the inspection we found the system was not effective and we continued to have concerns about the risk of harm to people.

● This shows that although the provider had reflected on the concerns we raised, they had not ensured lessons were learnt to avoid a repeat of the same concerns reoccurring.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were protected. This placed people at 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.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

● Service users were placed at risk of harm as risks were not always assessed or reviewed. A relative told us, "[Name] had a fall and caught their head on the cupboard, but they haven't put anything there to stop them falling again."

● Some people required regular turns to reduce the risk of pressure to their skin. There were no records in place to confirm if the person had been turned and the daily records for this person had not been completed for a 48-hour period. Staff confirmed they had been into the person; however, we could not be assured on the aspects of care the person had received during those visits.

● Some people had behaviours which could cause themselves or others harm. These were not managed. One relative said, "When [name] gets anxious they can be aggressive, they leave them in their room. They should know how to deal with them and the behaviour." We found information relating to managing behaviours had not been followed and this placed the person and others at risk of harm.

● There was no protocol in place to guide staff on the use of 'as required' medicines. Some people required this medicine for their anxiety. This meant people may not have received their medicine at the appropriate time to reduce their anxiety or support the management of their behaviour.
● Topical creams were not applied in line with the prescribed needs or dated when opened. For example, one person required cream to be applied three times a day. The records show the cream had not been applied daily since the 8 October 2019. We raised this with the provider after the first day. On the second day of the inspection we found that measures had not been put in place. Two people's records we reviewed required cream to be applied twice a day. The records reflected they had not had the cream applied. This meant people were at increased risk of sore skin.
● We found errors in the stocks of medicines which included missed signatures on the medical administration record. This meant we could not be assured that people had received the correct medicine in line with their prescription
● People had not been protected from the risk of infection. One person said, "I had spiders tiny ones in my bedroom and I have had to move out of my room it was awful." We found areas of the home to be untidy and unclean. Cleaning schedules had not been used to check that all areas of the home were cleaned to the required standard.
● The provider responded immediately after the first day of the inspection in relation to medicines management and areas relating to infection control. However, on our second day of inspection we found these systems had not been fully embedded and these areas continued to be of concern.
● The kitchen had a five-star rating, however we had concerns about the storage of cleaning chemicals in the kitchen and the disposal of rubbish. We found the rubbish had been stored in the kitchen corridor awaiting removal, however the mal odorous smell was overwhelming. This was disposed of at our request, however a system to ensure this did not reoccur was not put in place and we observed the same practice on our second day of inspection. The food hygiene rating reflects the standards of food hygiene found by the local authority.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. 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.

● We found staff used personal protective equipment when delivering personal care and when serving meals.

Staffing and recruitment
●People felt there was not always enough staff. One person told us, "There's not always enough staff and some people here that are in the wrong place." Another person said, "There is not enough staff here at the moment and recently there are lots of new faces."
● The new provider told us since their ownership many staff had left the service, and this meant there had been substantial recruitment needed. During this period, they had employed agency staff to support the home. Agency staff we spoke with had been regulars at the home, which support some consistency. However, there was a lot of new staff and information about care needs had not always been shared. This had an impact on the care which was delivered. We have reported on this aspect in the responsive section of this report.
● Staff performance had not been monitored adequately, staff had not received supervision for their roles.
● We reviewed the recruitment records for the service. We found there to be some gaps in the staff records relating to experience or records reflecting documentation for working in the United Kingdom. The provider was aware of these areas and we saw there was a review of the staff records.

We recommend the provider follow the national guidance for the safe recruitment of staff.

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 under the previous owners this key question was rated as Good. This is the first inspection at this location for this provider and this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received the required training to support their roles. For example, new staff had not received a comprehensive induction of the building or the skills they required. One staff member had received half a day and another one days training. Neither of these occasions had included moving and handling, safeguarding or infection control training.
- Where training had been completed we found that the knowledge was not embedded, and staff were unable to share with us the actions they would take to consider protecting people from harm in relation to safeguarding and the risk of infection.
- Staff had medicine competency assessments. However these were not effective as we found that the medicines assessment had not identified that the new system of stock recording had not been followed or that the staff member completing the administration had artificial nails. Artificial nails can harbour bacterium or other microorganism which can cause infections.
- The provider shared with us the training matrix, this identified when the training booklets had been issued to staff, however it did not show when the training had been completed. It also didn't reflect if the information had been understood and it was echoed in practice.
- Many people had bruising and the pattern of these showed they were on forearms, elbows and the front of the legs. These may have been indicative of poor moving and handling practices or the use of physical restrictions.

We found no evidence that people had been harmed however, systems were either not in place to ensure staff had received the required training for their role. This placed people at risk of harm. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People did not always receive a diet which was suitable for their needs. The cook and care staff had not been provided with any details relating to people's dietary needs. One person was given a meal which was not in accordance with guidance provided by the speech and language team (SALT). They were initially given a pureed meal which was refused. They were then given a meal with large lumps, the guidance for this person is 'soft and small lumps.' This placed the person at risk of choking.
- A whiteboard in the kitchen displayed information about people's diets, however some of the information was pertaining to people who no longer live at the service.
- Some people required thickener in their drinks, However, staff were not aware of the different consistency

each person should have. They proceeded to use the same ratio of thickener to fluid for each person. This placed people at risk of choking.
● People's weight had not consistently been monitored and we found some people had lost weight and no action had been taken to investigate why or raise with SALT.
● There was a handwritten menu in the dining room and the cook had been around the home asking people their preferred choice for the day's meal. One person said, "The food is reasonable and if you don't like something or do not want it you are offered something else." Another person said, "You can have choices there is enough. At bedtime you can have Horlicks." We observed during the midday meal some people requested a different meal from the one they had chosen, and an alternative was offered.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had received support from health care professionals. One person told us, "I have had one or two falls, they get the paramedics." However, we could not always be sure the required actions had been followed. For example, the advice in relation to diets had not been shared with the staff or cook to ensure the correct meals had been provided.
● Other guidance had not been followed in relation to the required support to reduce the risk of sore skin. For example, timed turns and cream application had not been completed or recorded.
● Health care professionals we spoke with told us they had concerns in relation to, 'footplates not being on wheelchairs, pressure cushions not in use, reminding staff with regard to regular toileting for some people and the generally untidy and cluttered environment.' They told us, "We reported on the required actions needed and things have improved recently, although we still have ongoing concerns in some of the same areas."
● People were at risk of accessing the kitchen and we found the door to be wedged open.
The provider responded immediately after the inspection. They had already identified the need to have a secure access fitted to the kitchen door. This work was brought forward and on the second day of the inspection this work was being completed.

Adapting service, design, decoration to meet people's needs
● The conservatory was used as communal lounge, and this had a small room to the side. However, this had been blocked off by a chair. This restricted people's flow of movement from one room to another. We also found that with most people sitting in the conservatory this made it a very crowded space. The implications of this meant that there was a risk people could trip on the walking aids or over people's feet when moving about. We observed this to be case when the room was full.
●People were able to personalise their bedrooms, however we found many of these to be cluttered and unclean. We found some rooms had dirty linen on the beds and the carpet was strained and had a malodour.
● Equipment which was used to support people's independence was not always clean or in good working order. For example, wheelchairs without footplates and the rotunda had a broken handle.
● People could access the patio garden through the dining room, we saw some people went out to smoke. One person said, "I come out here for a smoke and I have done some gardening I painted those planters and have planted those plants too I help the gardener." However, we found a tub full of cigarette ends on the exterior table which had not been emptied for some time.
● Many people using the service were living with dementia. There was no dementia friendly signage, to provide clues for people to the function of the rooms; for example, toilets, lounge or dining area. This meant people may be limited in being able to orientate themselves around the home.
● The provider was aware the need to make improvements and had put on an all-weather roof to the conservatory and commenced some areas of decoration.

We recommend that the provider considers current best practice in relation to the environment to support people living with dementia.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care and support did not always reflect current guidance and any information recorded about people's care had not been shared with staff.

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.
● People's capacity had been assessed and records showed that where people may be lacking the capacity to make particular decisions, a two-stage assessment of their capacity was carried out. However, when a DoLS request had been made staff had not maintained records to reflect why the person may require an authorised restriction. For example, one person was expressing wishes to leave the building as they were not safe to do so. Staff had not recorded these events and this could affect the assessor understanding the level of need.
●Staff were not fully aware of the requirements about consent to care and treatment. They had not received training or competencies to reflect their learning.
● There were no audits in relation to this information to ensure the processes and any authorisations were being followed.

We recommend that the provider seeks advice on best practice, to assess people's capacity in relation to specific decisions for people living at the service.

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 under the previous owners this key question was rated as Good. This is the first inspection at this location for this provider and 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.

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

- People's privacy had not always been considered. For example, one person had a fire door which accessed in to their room and this had not been appropriately fastened in respect of fire regulations. Another two rooms had an interconnecting door which had not been fastened which meant they could be accessed without the persons permission or knowledge.
- People's choices for their daily needs had not always been supported. Some people told us they would like more opportunities for a bath, however they were restricted to one a week. One person said, "Once a week we are allowed a bath I would like one more often, but I suppose they do what they can I would like one every night." Another person said, "I would like a bath every day, but it depends on the staff available at the moment, I have one a week."
- There had been no choices offered as to the gender of the care staff. One person told us, "We don't really get a choice if we want a male or female carer. I have a male carer sometimes, but it is a bit embarrassing."
- There was no information provided to reflect people's equality or cultural needs

We found no evidence that people had been harmed however, systems were either not in place to ensure peoples dignity was respected. This placed people at risk of harm. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection in relation to the issue relating to the doors. They had already recognised this and brought the work to this area forward. On the second day of the inspection we saw these areas had been addressed.

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

- People told us they had established relationships with the staff, although they also recognised there was a lot of new faces.
- Relatives we spoke with were welcome to visit at a time to suit themselves and they were made welcome. However, some relatives felt they were not always kept informed about the care their relative received or any incidents which may have occurred, for example a fall.

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 under the previous owners this key question was rated as Good. This is the first inspection at this location for this provider and this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People did not always have access to their call bells. One relative said, "Name has been ill in the past and they could not reach the call bell until we came and passed it to them. The staff encourage them to drink water and juice, but often the jugs are empty when we come." We did not observe any daily jug of fluids when people remained in their rooms.
- We found two people who did not have access to their call bells as the call bell cable was wrapped around the unit on the wall. Another call bell was not plugged in. This meant people may not be able to access timely care when it was required. We found all three of these people in need of care and had to request support on their behalf.
- The provider responded immediately after the first day of the inspection. They confirmed that call bells were in working order and arrangements made to ensure call bells would be made accessible. A new system had been implemented for the senior staff to check each person at 7.00am. However, on our second day we found at 8.30am two people who were in their rooms did not have access to their call bells as they were wrapped around the wall unit.
- Care records were not standardised, and some had not been reviewed since July 2019. Staff told us they did not have time to read care plans and relied on handovers. We reviewed the handover information, this did not provide staff with any elements of support to guide them. For example, if a person required equipment to move or had a specific diet.
- On the second day of the inspection we found information in the handover had not been followed up. One person had an injury, this was identified as needing a medical review. The district nurse was present in the home, however had not been asked to review the injury. This meant the person may continue to be in pain with their injury and that the system in place was not effective in managing people's current needs.
- At the time of this inspection one person required end of life care. They had a care plan; however, this was not always followed, and this impacted on the care the person received. Other people did not have an end of life plan and it was unclear to staff about decisions which may have been made about their care. For example, if any person had a right health care plan or do not resuscitate form in place. This meant people may not have their wishes followed when needed.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate peoples care was personal and reflective of their needs. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
● We saw no other methods had been considered, for example, easy read information or picture menus to support choice or objects of reference. This meant we could not be sure people had been supported or encouraged to communicate their needs.
● There was an information board in the reception for pictures of staff, however this was blank.
● The home had an information booklet, 'Service user guide' which related to aspects of the home and contact information. We saw that in one bedroom this information was on display, however it was out of date and not in a format suited to enable the person to access it.

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 felt they would like more opportunities to reduce their daily routine. One person said, "They should be offered some mentally stimulating activities." A relative we spoke with said, "[Name] misses being independent, and it would suit them to do a practical activity in their room such as dusting. I don't see people in the garden, they would like to go in the garden."
● There was an activities board on display and we saw staff singing with people, however there had been no engagement with people to identify any individual preferences or to encourage hobbies.

Improving care quality in response to complaints or concerns
● The complaints system had not been managed consistently. The last recorded complaint was June 2019. We were aware of complaints which had been made and there was no record of how these had been addressed.
● People and relatives were not well informed about any changes. One relative told us, "I have a problem with the way the staff communicate. People who have visited [name] have left a message and this had not been communicated, they should have a book that they note down all the messages."
● The provider had placed a comments box in reception, to encourage feedback on the service or any concerns, however the complaints policy was not readily available.
● This meant we could not be assured the provider was following their complaints policy.
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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 under the previous owners this key question was rated as Good. This is the first inspection at this location for this provider and 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; 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

- There was no registered manager in post when we inspected. The provider had recruited a new manager who was completing their recruitment checks. In the interim the providers had commissioned consultants to support the day to day running of the home. However, we found there was no clear approach to the management of the home and this impacted on areas of care being missed. For example, not providing person centred care, managing the staff and ensuring quality improvements to the home.
- The provider or nominated individual had not established clear supervision or management of the home. We found that audits had not been completed or any identified actions followed up.
- There had been two medicine errors in August 2019, the last audit completed was July 2019. An initially follow up in august 2019 had identified that actions from the July audit had not been followed. Despite this no further audit or ongoing checks had been considered, or measures taken to reduce the risk of further errors with medicines. This shows a lack of continuous learning and improvement.
- Accident and incidents had not been reviewed since July 2019. Where incidents had been recorded there was no investigation or action identified to reduce the risks to people. There was no trend analysis to consider if any person, time or area of the home was of concern.
- The provider had not managed the risks in relation to staff training. An incident had occurred in July 2019 relating to moving and handling. No detailed investigation had been completed or consideration made to staff training. We saw that care staff had commenced their caring duties without the required training and a further incident had occurred in October 2019, this led to harm to a person. The identified staff had not received training in moving and handling and reflects there had been no learning from the previous incident.

- The last infection control audit had been completed in September 2019. However, this had not identified areas where the home didn't meet infection control standards, we have reflected these concerns within this report.
- The daily running of the home had been assigned to the senior care staff who had only been at the home for three weeks and they told us their role was as a consultant. They had limited knowledge of the people and the care support they required. On the second day of the inspection the senior care staff managing the daily care had only been in post for one week. They were unaware of people's needs and the areas to direct

and guide staff.
● We found notification for some events had been completed. However, the provider was unaware of all the required notifications they should complete. For example, the home had an issue with their heating boiler for over a week, this should have been reported to us so that we could monitor how people continued to be supported. Other notifications had not been completed when people had unexplained bruises or when people were a risk of injury from each other due to their anxiety. This meant we could not be sure the provider was being open and transparent.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good 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
● There was a mixed approach to the culture of the home. People and relatives, we spoke with were unclear as to who or how the home was being managed.
● Peoples care needs were not always being met as detailed in this report and this had an impact on their safety.
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had not been consulted on their care and there had been no meetings for people using the service.
● There was a survey was in the reception of the home, however there had been no drive to obtain feedback on the home and none of these had been completed. One relative told us, "I don't think I have been asked to fill anything in or go to meetings."
● None of the residents or relatives we spoke with had been invited to attend meetings for people who use the service, and none had been asked to complete questionnaires.
● People had not been consulted on the menu, we saw on the second day of the inspection the menu had been changed from a two-week menu to a four-week menu, this was to provide more variety. However, people had not been consulted in this process or given the opportunity to contribute.
● Staff had not been informed or consulted about changes in the home. There had been no meetings to reflect these areas so that staff felt involved in the home.
● There was limited understanding or consideration of the equality characteristics relating to the needs of people or staff. For example, the gender preference for people who received care or supporting people with their disability.

Working in partnership with others
● The provider had received a visit from the local authority in August 2019 following complaints and whistle blower concerns we shared. They were asked to complete a review and action plan on how they would address the concerns. However, when we completed our inspection an action plan had still not been completed and we saw a continuation of the concerns raised.
● The district nursing service had raised some safeguards in relation to the safety and care of people. No detailed investigation had been completed, or measure put in place to ensure the risks had been mitigated. We saw that areas of risk continued to be a concern.
● This shows that the provider had not worked in partnership with health and social care professionals to ensure the safe and care treatment of people.

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 had not ensured the care plans were completed and reviewed. People had not been consulted about their care and preferences. Responsive care was not provided consistently.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not always respect people's dignity and this may have an impact on the person feeling valued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured the staff received training at a relevant level to provide them with the skills to keep people safe at all times.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. The provider must ensure the premises used by the service are safe to use and for their intended purpose. Risks were not always managed.

The enforcement action we took:

NOD to restrict admissions and positive conditions

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 The provider had not ensured their processes were robust to protect people from harm. Staff had not received training relevant to their role to enable them to recognise different types of abuse and how to report concerns

The enforcement action we took:

NOD to restrict admissions and positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made. Risks had not been reviewed placing individuals and others at risk of harm. Experience of using the service had not been obtained from people. Communication with people using the service and those important to them had not been established to share how the

home was being managed.

The enforcement action we took:

NOD to restrict admissions and positive conditions