Ashgate Care Limited

# Ashgate House Care Home

## Inspection report

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Date of inspection visit:
28 January 2020

Date of publication:
13 March 2020

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Ashgate House is a care home providing personal and nursing care providing support up to 45 people. On the day of inspection 39 people were residing at the home. All of the people living in the home are living with dementia, some with complex needs. The home is split into two units, the older original building with lift access to the second floor and a newer ground floor extension. Both areas contained communal spaces and the rooms in the new extension had ensuite facilities.

People's experience of using this service and what we found
People's care and treatment needs were not always managed safely. Risks associated with people's care and support had been identified, however, from records and observations staff were not supporting people in line with their assessments. Therefore, risks were not managed safely. We identified concerns about out of date risk assessments, prevention of pressure ulcers, nutritional risk and poor moving and handling practices. Further improvement was also needed in accident and incident reporting and auditing systems.

Care plans were person centred, however not all staff had seen or were aware of the contents of plans. Staff we spoke with understood people's needs however, as they had not seen the care plans we could not be sure they respected people's choices or were guided to people's current needs. End of life care plans were very sparse and did not contain people's preferences.

There was a high turnover of staff which was affecting recommended staffing levels and a high use of agency staff. Recruitment processes were ongoing to increase staffing, systems and processes were not sufficiently robust to support new staff. Improvements were needed to ensure all staff adhered to best practice guidelines. Staff told us more incidents and accidents occurred due to reduced staffing levels. New staff to the home were not sufficiently supported or orientated to the environment.

Medication systems were in place however, guidance for these were not always followed such as requirement for as required medication instructions. Further improvement was needed in medicines storage management.

There was not a positive culture within the service. Several staff expressed concern about some people's wellbeing and told us they were unable to provide appropriate support to some people. The approach to promoting people's independence was inconsistent. People were supported to have maximum choice and control of their lives and staff did support them in the least restrictive way possible and in their best interests; the policies and systems in the service did support this practice.

On the day of our inspection we saw limited activities taking place and there wasn't enough to occupy the majority of people. Activities were dependent on the availability of the activities co-ordinators and were dependent on staffing levels.

Systems to monitor and improve the quality of the service were not always effective due to lack of oversight of poor practices. Systems were in place to ensure equipment was safe and in good working order. We found the home was generally clean however, noted a malodour in some communal areas. Bedrooms had been personalised and communal areas were comfortably furnished. However, areas of the service were not adapted to meet the needs of people living with dementia in relation to signage to support orientation. Where audits had identified areas for improvement, action had not always been taken to address issues.

Following our feedback, the provider responded immediately and increased staffing levels and voluntarily agreed not to admit any new people for a period of time until improvements are made. An action plan reflecting all the areas requiring improvement was developed.

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 4 August 2017). At this inspection the rating has deteriorated to Inadequate.

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

Enforcement
We have identified breaches in relation to dignity and respect, person-centred care, safeguarding, safe care and treatment, staffing, and leadership and oversight 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
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?**

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?**

Requires Improvement

The service was not always 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.

# Ashgate House 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and one specialist nurse advisor.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioning and safeguarding teams and health professionals. We used the information the provider sent us in the provider information return. This is information 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. We used all of this information to plan our inspection.

During the inspection
We met people who used the service and spoke with two relatives about their experience of the care

provided. We spoke with 12 members of staff including the registered manager, deputy manager, nurse, cook, domestic staff, team leaders and care workers including agency care workers.

We reviewed a range of records. This included parts of ten people's care records and multiple medication records. We looked at four 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. We spoke with one further relative by telephone. We shared our concerns with local commissioners and safeguarding authorities to ensure there was a review of some people's current care.

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 Good. At this inspection this key question has 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

- People were not always safe and safeguarding was not given sufficient priority. For example, we saw some people had been victims of abuse from another person, the staff simply moved the person away, which meant the immediate risk to safety and well-being had been mitigated. However, the staff failed to review the incident and consider how to reduce the risk reoccurring.
- One person we saw, approached two other people on at least three occasions, touching them inappropriately; and on another occasion attempted to physically lift a person from their chair. Staff only intervened after these events had occurred. This meant they were responding reactively, rather than preventing the issues from arising.
- The registered manager told us they had reviewed the risks and provided assurances there would be continual oversight of the lounge. However, we saw on two occasions during inspection there were no staff in the communal space. These incidents demonstrated a lack of oversight to ensure all people were safeguarded effectively from others.
- Staff had received training in recognising and reporting abuse however, they had not recognised potential abuse and reported it.

People were not safeguarded from the risk of abuse which 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

- Risk was not always managed safely. For example, some assessments contained contradictory information within their care plan around their dietary needs that could have caused staff to make mistakes. We saw staff using a hoist for a person, who had not been assessed for this equipment. This was after other attempts to move the person had caused the person distress.
- Some people required regular turns to reduce the risk of pressure to their skin. We found two people's records showed they had not received the required support to reduce the risk of sore skin. Other records had not always been completed to provide us with the assurance that people had received care in line with their care plans.
- Not all staff attended handover and so did not receive information to understand people's current needs. Staff told us they had not read the care plans and relied on the handover information provided before they commenced their shift. For example, staff were told to increase someone's fluid intake, however were not provided with a reason, or guidance how to achieve this. There were detailed behaviour plans however, these had not been shared with staff to provide a consistent approach to managing people's anxiety or

behaviours, and this placed the person, others and staff at risk of harm.
● When people received their medicines covertly staff had not received guidance from the pharmacist to ensure medicines could be used safely in this way. When people required 'as required' medicines there was not a protocol in place to provide staff with guidance of when these should be administered. This is extremely important information for where people are unable to vocalise their pain or discomfort.
● The storage of medicines was not in line with their policy or current guidance. For example, the treatment room temperatures were not always recorded, and we found the medicines room was above good practice guidance for temperatures. This could impact on the integrity of the medicines. New medicines delivered the previous day, was placed in the corridor and not securely locked away. No longer required medication and controlled drugs had not been returned or disposed of as per the homes policy.
● People had not been protected from the risk of infection. We found the bathroom area contained people's personal items, inappropriate material being used to hold the bath plug and the back of the bath chair was ingrained with soap scum. The cleaning schedules had not identified this. There was a malodour present in some communal areas.

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.

● Staff had received training about current best practice guidelines and wore appropriate personal protective equipment such as disposable gloves and aprons.
● The kitchen and food preparation area was well maintained. There was a five-star rating from the food standards agency, which is the highest possible rating. The food standards agency is responsible for protecting public health in relation to the safe handling of food.

Staffing and recruitment
● Staffing levels were insufficient to provide adequate care for the current number of people. Some people required staff to support them on a one to one basis. These staff had been included in the care numbers and this meant there was not always sufficient staff to meet people's needs. We observed the one to one staff supervised the communal spaces which impacted on the care for the person they were supporting.
● Staff told us they were concerned about staffing levels and had raised their concerns to the registered manager in meetings. Minutes of a recent staff meeting noted "There should be one member of staff circulating around the lounges at all times in order to defuse possible negative interactions between residents and to assist residents who are mobile." We observed periods when the lounge area was unsupervised, and incidents then occurred.
● The registered manager used a dependency tool. Some staff were included in the numbers to provide basic care. However, they spent several hours administering medicines and completing paperwork which meant they were not available to provide hands on care. This placed additional pressure on other staff and at times people's needs were not met in a timely way due to this arrangement.

Staffing levels were insufficient to provide safe care. This was a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider responded immediately after the first day of the inspection to increase staffing levels and placed the nurse as supernumerary.
● Safe recruitment practices were being followed to recruit new staff into the service. The necessary steps had been taken to ensure staff suitability before they started working with people, for example, criminal record checks and references from previous employees.

Learning lessons when things go wrong

● We found some lessons had been learned for example, since the last inspection the provider had installed a digital system to record the ordering, receipt, storage, administration and disposal of medicines. The system guided staff how to how to safely administer medicines and would flag up immediately if a medicine was missed. A recent incident confirmed this procedure worked. We completed a stock check of some medicines we picked at random and found these to be correct.

● However, some areas were not always reviewed effectively to protect people from risk, for example, where people had accidents or had been involved in incidents with other people, staff had not always completed the appropriate paperwork. This meant there was no thorough investigation or clear documentation, which meant there was no consideration in how to reduce the risk for these instances.

Requires Improvement

# Is the service effective?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● The provider shared with us the training matrix which showed some staff had received training. However, other staff had not received the required training to support their roles safely. For example, new and agency staff had not received a comprehensive induction of the building. One staff member had commenced work without adequate training including moving and handling, safeguarding or infection control training. A staff member told us they 'felt out of their depth'. This member of staff had been told they would be shadowing experienced staff but they were left alone in a communal area, whilst three people were eating lunch. This meant the new staff member was unsupervised whilst assisting people to manage diet and fluids. They were also left to supervise people who expressed their anxiety in ways the staff member had not been guided how to manage.

● Staff had received training in managing behaviours that challenge. However, no competency assessments had been completed and staff showed limited understanding in managing people's behaviour. For example, some staff used distraction techniques, other staff simply removed the person from the situation and other staff were unsure of actions to take.

● A number of people had been admitted to hospital following falls. However, some of these people it was later identified had an infection. Best practice guidelines were not implemented as staff had not received training in recognising common indicators such as Sepsis awareness, or recognising symptoms of Delirium.

● Agency staff had not received an induction or safety orientation of the home before they commenced their shift. The registered manager told us that agency staff completed a check sheet with a senior member of staff on their arrival. However, there were no records produced for the agency staff on duty on the day of the inspection.

● During our inspection we heard the emergency buzzer ringing for a long period of time. The explanation was the agency staff did not know how to use the system properly, had set it off inadvertently and did not know how to cancel it.

We found no evidence that people had been harmed however, systems were not in place to ensure staff had received the required training or achieved competencies 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 were not always supported to eat and drink enough to maintain a balanced diet. We looked at records of people's fluid intake and saw these did not include how much fluid people needed on a daily

basis. One person's care record said they were on a food and fluid chart but there were no charts in place to record their intake. Another person who had a record only had one minimal fluid recorded for a whole day.
● On further review of people's food and fluid charts, we found there was inconsistency in the recording. For example, one person was on a pureed diet and the initial records reflected this person had received food which was inappropriate for their dietary needs. We observed when this person received their meal and this was in line with their current plan. This inaccurate record raised concerns about our assurances around the provision and recording of people's meals. Some people were at increased risk because assessments and guidance were not clearly followed, and staffs recorded support was inconsistent.
● We observed the midday meal and found it wasn't a pleasant experience in all areas. The main dining tables were bare, no table clothes, napkins or table menus visible. There was no atmosphere over the lunch period; people were not encouraged to engage with one another.
● Consideration had been made for people who previously enjoyed their hot meal in an evening. We spoke with the cook who explained most people were used to having a light lunch and their main meal in the evening. This was promoted each day, except for Sundays when the main hot meal was served at lunchtime.

● The cook demonstrated awareness of dietary needs, had knowledge about people's meal requirements and provided choices to support these. This included cultural meals.

Adapting service, design, decoration to meet people's needs
● The home predominantly supported people living with dementia. However, there was a lack of dementia friendly signage and pictorial images used to help people living with dementia or sensory impairment to orientate the building. We read in some people's care plans that they had difficulty finding their way around the building or locating the bathroom, or their bedroom.
● People's individual bedrooms had been personalised with their own belongings, photographs and ornaments.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Although the tools the service used to assess people's needs were nationally recognised, they were not always used effectively. People did not always receive best practice care about effective prevention of pressure ulcers, weight loss and moving and handling techniques. We have reported on this further in the 'Is the service Safe' section of this report.

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 living with dementia were subject to some restrictions whilst living at the home. Records of decision specific assessments around capacity and best interest decisions had been completed but not always decision specific, applications were forwarded when required to the relevant authority. Staff had received training, however were not all familiar in the process for decision making, or the understanding of

DoLS.

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

● We saw there was evidence of communication with healthcare professional teams. Staff referred people to the appropriate healthcare professional in a timely manner and advice had been sought from other professionals, such as GP's and specialist response teams. The registered manager or nurse on duty ensured information from external professionals was incorporated into care plans.

● Oral health had been considered in care plans and current best practice was being further considered in relation to this being incorporated into people's care and staff training.

Requires Improvement

# Is the service caring?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People's dignity was seen to be compromised. One person was left for an hour, whilst the carer was waiting for further staff to come into the lounge, so they could support them with their personal care, as two staff were required to support the person.
- One person returned from the hairdresser and removed their clothing in the communal area. This action engaged another person to behave inappropriately. The staff member was uncertain how to manage the evolving situation and had to request support from another staff member.
- There was a lack of consistency in the quality of support people received. Some staff knew the people they supported well and showed understanding of what mattered to them and the support they needed. Other staff had very limited understanding of the people they supported and appeared to be present in a supervisory capacity only.
- People were seen walking in socks, with no slippers or shoes around the home which could pose slip hazards and another person was walking around the home with only one shoe on which did not uphold their dignity.
- Several staff expressed concern about some people's wellbeing and told us they were unable to provide appropriate support at times due to their struggle to manage the behaviour of others. This had a negative impact upon the quality of care these people received.

People were not treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
- We observed there appeared to be too few staff to meet the individual needs of people safely and effectively. Staff were reacting to situations, which gave a chaotic feel to the service being provided, rather than being proactive and supporting people to be involved with decisions about their care.
- The provider did not recognise the importance of ensuring staff had the time and skills to offer people compassionate support. Staff did not have time to sit and talk with people for any meaningful length of time.
- We saw some examples of people being encouraged and involved in decisions, such as in choosing what they wanted to wear, what to eat and to some degree how they wished to spend their day, however this was limited to people who did retain some level of ability to engage more with staff.

Ensuring people are well treated and supported; respecting equality and diversity

● Several staff were caring and spoke to people with kindness and patience, we saw evidence of kind and caring communication which confirmed this. However, staff were often busy, and task orientated which meant they did not have time to spend with people to provide any quality interactions.
● We saw in communal areas staff were often in a supervisory role, rather than to provide companionship to people. We observed lunch and one person was taking other people's sandwiches off their plate, this happened on several occasions that staff did not see because they were busy.
● Several staff we spoke with felt morale within the team was low and staff often missed breaks to ensure they continued with support to people.

Requires Improvement

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- People's needs and choices had been explored and documented. However, this information was not shared and meant care was not always delivered in a person-centred way. For example, staff were not familiar with people's individual preferences and choices.
- Staff were not provided with the right guidance when providing care to people. We saw staff with scratches sustained from providing care to people who were very anxious when they received personal care. Staff told us they had reported these numerous times, however were told this was part of the job working with people with this type of condition.

- People's social, emotional and wellbeing needs were not always met. We observed people's care was often incorporated into the routine of the home, or of staff; rather than people's preferences. Staff were task focused and people spent a lot of time sitting in the lounge or following staff around, as there was little to occupy them. Staff only appeared to engage and communicate with people during periods of care delivery.
- People were not supported to follow interests or take part in activities that met their needs. Some people had the support of a one to one staff member, but they did not always focus on the individuals needs. For example, one person continuously walked around the communal space without any stimulation. Other people were discouraged from walking around and staff were overheard asking them to 'sit down'. Once seated, no provision for occupation was made, despite objects which could have been used being in the lounge area.
- There were two activities staff employed at the home however, we observed there were limited opportunities on the day. Some people remained in their bedrooms all day, we did not see any specific social interactions, or equipment being taken to their rooms to stimulate people.

We found no evidence that people had been harmed however, the failure to consistently provide person centred care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- People had not been adequately supported with information or provided with different methods for

communication. We saw one person had communication information in their care plans, but this information was not then utilised in their activities assessment. We saw no other methods had been considered to meet people's needs. For example, there was no evidence of easy read information, or pictorial images to support choices, or objects of reference. This meant we could not be sure people had been fully supported or encouraged to communicate their needs.

End of life care and support

● People's choices for their end of life care had not always been considered and were not clearly recorded, communicated or kept under review. Although there was information for funeral plans in records there was no record of the persons historical wishes around what they would have wanted. Care plans are important to ensure that people's last wishes and preferences had been considered and where possible supported.

● We spoke with the registered manager and they told us there were currently people at the home receiving end of life care. The manager told us they would look at the care plans for these people in more depth to ensure their needs and preferences were included and plans were in place for future engagement with end of life care specialists.

Improving care quality in response to complaints or concerns

● Information about the complaints policy and how to complain was shared with relatives.

● Any complaints received were handled as per the provider policy. However, some staff told us that if they raised a complaint they didn't receive an answer or felt the management did not adequately respond to them.

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 Good. 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; 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; Continuous learning and improving care

- Daily records and care plans were not always accurate and had not been updated to reflect whether people's assessed needs were met. This meant people were at risk due to lack of oversight with the quality monitoring systems. Where responsibilities such as recording dietary intake and monitoring weights had been delegated, there was poor oversight meaning people were placed at risk in relation to their nutritional needs.
- Communication system failures within the staff team at times of handover, meant information was not appropriately shared with care staff. Staff were not given the opportunity to reflect on their responsibilities appropriately because incidents were not always recorded or reviewed, for them to understand how these could have been managed any differently.
- Not all staff felt supported or assured that when they raised concerns these would be acted upon. For example, the staffing numbers and management of physical interventions. Some staff expressed their supervisions were not beneficial for their own development.
- Systems of assessing competencies and observations of staff practice had not identified poor practice and did not reflect on current care provision. There was a reliance by the registered manager that completion of training had ensured staff understanding of their role and responsibilities.
- Audits of accident and incidents were in place and completed monthly. However, some incidents were not recorded as such, which meant action plans were not developed to prevent any reoccurrence. Themes and trends were being identified, but not effectively; therefore, it was not possible to demonstrate how any of the completed audits were informing practice or leading change.
- Systems of governance were not effective to monitor and mitigate risks to people. For example; quality assurance audits had not identified the concerns we raised at this inspection with regard to management of risk for people, staff embedding their training and the environmental risks identified.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate good governance 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

● The culture within the service was not consistently positive. Staff spoke about low morale, lack of adequate staffing levels and not wanting to work with certain staff. Comments included, "Some staff want to be here and go above and beyond, but not others." and "I don't feel like a valued staff member."

● One relative we spoke with informed us the registered manager communicated with them when accidents or incidents had occurred and updated them.

● The registered manager had submitted statutory notifications as required. This is information about events occurring at the service, which the service is legally required to notify CQC about.

● The service displayed their previous rating as they are required to do.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● CCTV had been installed summer 2019 and was in operation throughout the home. A data protection impact assessment had not been completed which is best practice when using surveillance equipment. This provides details of how the CCTV would be used and any footage stored. Although relatives had been informed during a meeting, the details had not been incorporated into the homes Statement of Purpose. This was immediately addressed by the registered manager on the day of inspection.

● Staff did not always feel supported. Minutes of meetings showed the registered manager held staff meetings with both day and night staff. However, staff told us the meetings weren't very positive and didn't resolve issues. One staff said, "Every time we mention staffing, we are just told we have the numbers. For accidents and incidents – we get a run down on the numbers occurring, but don't talk about any action to reduce the risk."

● Satisfaction questionnaires and face to face meetings were completed and attended by relatives. There were still outstanding actions from the relatives meeting held summer 2019 which had discussed the use of staff boards to identify who key staff were and we saw issues around staffing levels had been consistently raised.

Working in partnership with others

● The service worked with others such as health and social care professionals. They ensured that appropriate referrals for support were completed as required. However, we found some support given previously with the involvement of the local authority and CCG particularly around behavioural management had been maintained in the care plans, but the resulting guidance was not always followed by care staff.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br>People did not always receive person-centred care or support with their emotional well-being and social activities. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br>People's dignity was not always respected. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br>People were not always safe in respect of risk assessment, medication management and infection control. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br>Safeguarding's were not always being recognised and notified. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br>Staffing numbers were not sufficient to meet |

Diagnostic and screening procedures

Treatment of disease, disorder or injury

people's needs. Staff had not always been provided with the required induction or training to support their role.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was not an open culture with the home. Effective systems were not in place to assess, monitor and improve quality of care. People were not always engaged in sharing their opinions about the service, and their views used to drive improvements. |

**The enforcement action we took:**

Warning notice.