Somerset Care Limited

Carrington House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Carrington House is a residential care home providing personal care without nursing for up to 44 older people. At the time of the inspection there were up to 33 people living in the home.

The home is purpose built and has a mixture of single bedrooms which were either en-suite or had access to communal bathrooms. It is spread over three floors with shared living spaces such as dining rooms and lounges.

People's experience of using this service and what we found
People were not always receiving safe care. Concerns were found with risks such as pressure care and moving and handling. Care plans lacked details and guidance to support staff to follow best practice. Medicines were not always managed safely. Systems to manage safeguarding people from abuse were not effective. People were not supported by enough suitably qualified and experienced staff.

As part of the COVID-19 pandemic we look at the infection control practices in care homes. Staff did not understand how to safely use personal protective equipment (PPE) such as gloves, masks and aprons. Throughout the inspection we observed staff incorrectly wearing masks such as below their nose or under their chin. The registered manager had not accessed support from the local authority to help change the culture until we prompted them. During the inspection contact was made after prompting by the inspection team.

People were not always supported in a dignified and respectful way. This was not in line with the provider's vision. Staff's interactions with people were task based and a lack of social interaction was witnessed. The management were not always facilitating a positive culture.

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.

The service was not well led. The registered manager lacked understanding of their roles and responsibilities. Concerned found during the inspection had not always been identified by the management or provider. The provider's policies and procedures were not always being followed. Quality assurance systems were not effective at driving safe and quality care. During and following the inspection the provider produced action plans to mitigate immediate risks to people.

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 31 October 2018).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns we had received about the service. The inspection was prompted in part due to concerns received about the management of risks. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the management of risks, eating and drinking and infection control, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing, people being treated with dignity and respect, protecting people from abuse, capacity and consent and effective management at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our effective findings below.	**Inadequate**

Carrington 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors and an Expert by Experience who made phone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector carried out the first day of inspection. Two inspectors went to the home for days two and three.

Service and service type
Carrington 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 on the first and second days. The final day was announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 spoke with 12 people who used the service and one relative about their experience of the care provided. We spoke with 13 members of staff including representatives of the provider, the registered manager, care staff and auxiliary staff. Throughout the inspection we carried out observations of the support people were receiving.

We reviewed a range of records. This included 11 people's care records and medicine records. We looked at three 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 continued to look at a variety of records including care plans, quality assurance records, training data and policies. An Expert by Experience spoke with 12 relatives on the telephone and we spoke with the local authority.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were placed at risk of abuse because the registered manager lacked understanding about their responsibility around safeguarding. The registered manager's response was not in line with the provider's policy and the local authority safeguarding policy. This meant potential abuse was not being recognised or managed in line with current best practice.
- Systems were not always protecting people from potential abuse. On the last day of inspection, the registered manager was speaking with one person in the dining room about unexplained bruising on both wrists. Action was taken to ask for a review with their GP. No consideration had been made by the registered manager, until prompting from the inspection team, of raising the bruising as a potential safeguarding. This referral was completed the day after the inspection.
- Another person in distress showed a negative reaction when the registered manager was speaking with them. The registered manager was not concerned at the reaction until prompted by the inspection team. The person's care plan contained no information about the explanation about the distress that was provided later to the inspection team.
- Staff felt that they could raise things with the management. However, there was mixed feelings about whether appropriate action would be taken. Some staff members raised concerns with the inspection team about poor practice or potential abuse they had witnessed. These were followed up with the registered manager and representatives of the provider to keep people safe.
- People were at risk of restrictive practices that limited their choice and control. At times these were blanket decisions that had not followed current legislation. Staff and the management had not recognised these practices as an issue. One person became distressed as a result of one of these restrictions.

Systems were either not in place or robust enough to demonstrate safeguarding was managed appropriately. This placed people at risk of abuse. 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.

- Relatives mainly felt their family members were safe living at the home. Comments included, "I feel Mum is safe, without a doubt. It is a secure location, and she has her lifeline button in her room", "I am sure she is safe. To be honest I have nothing bad to say" and, [Person] initially went for respite, but decided [they] wanted to stay there as [they] felt safe."
- People were supported by staff who understood how to recognise signs of potential abuse. Staff were able to describe what they would look for including bruising and unexplained marks.

Assessing risk, safety monitoring and management

● People were not kept safe from harm in relation to some risks. Prior to the inspection five people had pressure ulcers who were identified as high or very high risk of pressure ulcers. We found people were still placed at risk of developing further pressure ulcers.

● Two people whose risk assessments identified them as very high risk of pressure ulcers were not repositioned in line with their care plan. For example, one person who should have changed positions every two hours was recorded as lying on their left side. Yet they were positioned on their right side, which was the side they had been on all morning. This was acknowledged by the management.

● Records around repositioning were mixed and at times did not correspond with each other or with positions people were found in. Therefore, there was no way to monitor if staff were following the requirements. In daily records there were up to three methods of recording repositioning and all these were inconsistently used. A senior staff member stated only one method should be used in line with provider policies.

● People were placed at risk of harm when needing support to move from one place to another and moved around in bed. One person was repositioned in their bed by staff using a bed sheet rather than a specialist slide sheet. This placed them at risk of injury to their skin, for example, friction damage.

● Another person had a recommendation from a health professional for staff to use a hoist due to a deterioration in health. Their current risk assessment did not reflect those changes. No staff members were trained to write or reassess the person's risk assessments in line with these changes. On the second day of inspection the person had been hoisted out of bed. This meant they were at risk of being harmed during the process. The provider brought in a trained member of staff on the third day to update this risk assessment.

● Staff had not received adequate, practical moving and handling training and competency checks to prevent people from being harmed during repositioning. Of the 49 staff, 36 had not had practical moving and handling training or recent competency checks. The registered manager explained some of this was due to the COVID-19 pandemic. Another reason was no one internally was trained to complete the competency checks.

● High risk tasks had not always been identified as requiring risk assessments and guidance in place for staff in line with current best practice. For example, if people had catheters there was a lack of information to ensure staff reduced the risk of infections spreading.

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.

● Concerns were found on the first day of inspection in relation to health and safety. This included tying up out of reach of emergency cords in bathrooms and inappropriate waste bins. These had been rectified by the second day of inspection.

● Systems to manage health and safety were in place including around fire safety.

● Following the inspection, the provider sent an action plan about how they were going to mitigate immediate risks to people.

Staffing and recruitment

● People were not supported by enough suitably qualified and experienced staff to keep them safe and meet their needs. Throughout the inspection people were waiting for call bells to be answered at busy times. For example, one person who had a high risk of falls was mobilising using a walking frame round their room for around 15 minutes despite their pressure mat triggering the call bell to ring. Their care plan stated they should be supported by a staff member when moving. This placed them at risk of harm from falling which they had a history of being hurt.

● Another person calling out and using their call bell frequently had staff members not checking them when walking past the bedroom or when turning off the call bell despite calling out. The registered manager and staff said that this was a known issue. The person's care plan contained no information or guidance for staff in response to this. This meant they could be in pain and staff were lacked knowledge or understanding of how to help this person. A representative of the provider took action to follow this up when they were made aware by the inspection team.
● Relatives had mixed feelings with many raising concerns about staff levels when they have visited or spoken with their family member. Comments included, "They have had staffing problems…They have used a lot of agency in the past", "[Person's] concern is the high turnover of staff, especially during COVID-19. There were limited numbers" and, "There is a high turnover of staff, [person] often comments that there are not enough staff on to do what needs to be done. [Person] has said that in the last couple of weeks [they] have felt forgotten about."
● Staff felt there were not enough of them to meet people's needs and keep them safe. One staff member went through all the people requiring multiple staff to support them which had increased. They explained even though they received the rota the month before, gaps were still present the day before. Other staff explained it was also the combination of putting young, inexperienced staff together making it difficult to run a shift safely. Examples of poor planning of shift covers were given to us by staff members including last minute changes.
● Individual dependency tools were in place for people to enable staff to assess their needs. The registered manager shared their target staff levels. However, little consideration had been taken about the combination of staff on shifts including skills, training and experience. Therefore, on one shift a supervisor told us they were left with a team of inexperienced, young staff who required more support. This placed people at risk of harm and poor care due to staff having inadequate experience and training.

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not in place at the home. This placed people at risk of harm and poor care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people told us they did not have to wait long for their call bells to be answered. A relative said, "I do not quite know how the staff is worked out, but when I visit during the day there are always lots of staff around."
● People were supported by staff who had been through a safe recruitment process. Checks had been made prior to them starting.

Using medicines safely
● People were not always having their medicines managed safely. Two people were having their medicines administered by staff from their original packets into dosette boxes. The people then independently administered their own medicine. One person's risk assessment was completed on the first day of inspection after it was found they did not have one. This meant there was a risk the medicines could be damaged or increase chance of errors. The registered manager had not identified this practice as not in line with best practice or company policies. During the inspection they began making arrangements to stop this practice.
● Multiple medicine errors had occurred where stock had run out. One incident, prior to the inspection, recorded the person had gone without one medication for five days. The registered manager informed us the night staff were responsible for the errors which had been made prior to the inspection. No competency checks had been repeated and the staff members who made the errors lacked training in stock control which was part of the provider's required training. At the time of the inspection the staff were still working at night with responsibilities around medicine management, without action having been taken, placing people

at risk of running out of stock.
● People's medicines were stored in locked cupboards in their bedrooms and the temperature was checked once a week. No systems were in place to provide assurance the temperatures were safe at any other time. This meant there was a risk medicine could be damaged if it became too hot. The registered manager told us if the temperature went above 25 degrees Celsius then they would monitor daily for seven days.

Systems were either not in place or robust enough to demonstrate medicine was effectively managed to keep people safe. 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.

● People were administered their medicines in a kind and caring way in line with their preferences. The staff ensured one person was sitting correctly prior to be administered their medicines. One relative said, "Medicines have never been a problem."

Learning lessons when things go wrong
● Lessons were not always learnt when things went wrong. For example, care plans were not always updated with changes that had been made. Staff continued to manage medicines without being retrained or have their competency checked. When people were raising concerns about their meals then a short-term solution was found rather than resolving the issue. This meant some people were buying alternative food for meals.
● The provider had a system where all accidents, incidents and concerns were recorded. Senior members of the provider had oversight of this. However, due to the COVID-19 pandemic they had completed minimal onsite reviews.

Preventing and controlling infection
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. Multiple staff throughout the inspection were witnessed incorrectly wearing their face masks. This was despite us raising concerns with the registered manager. A senior staff member had to remind staff how to wear masks correctly during a handover meeting; one member of staff had their mask below their nose. One staff member was unable how to recall the sequence of how to safely remove PPE.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the

current guidance.

We have also signposted the provider to resources to develop their approach.

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 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.

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 were at risk of having decisions not made in line with current legislation. Two people with fluctuating capacity had restrictions to their en-suite bathrooms with no completed mental capacity assessment or best interest decision. One of the people became distressed when we asked about their bathroom being locked. This meant it had not been demonstrated the action was the least restrictive, other options had been considered or it was in the person's best interest.
- Completed consent forms did not always include whether the person agreed to the decision being asked. For example, one person had a consent form for COVID-19 testing however, whether the section to confirm their consent was not completed. This meant it was not clear for others whether there was consent for each decision.
- Some people had uncompleted consent forms. For example, there were blank forms around consent to being included in videos and photographs. This meant people were at risk of appearing in videos and photographs against their wishes or best interest.
- Relatives making health and welfare decisions for their family members did not always have appropriate authorisation to make these decisions. Examples were found of relatives signing consent for people on health and welfare decisions with only power to consent for property and affairs.
- Staff lacked understanding of how to apply the legislation because they lacked training. The training competency records provided demonstrated only 43% of staff had completed training on the MCA.

Systems were not in place to make sure decisions were made in line with current legislation. This placed people at risk of having their human rights breached. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who lacked capacity did not always have DoLS applied for in line with restrictions placed upon them. Seventeen people were found to have no DoLS application completed which meant they were potentially unlawfully deprived of their liberty.
● Staff lacked training in relation to DoLS. The training records shared with us demonstrated only 38% had completed the training.
● The registered manager did not understand the principles of how to apply DoLS to people living in the home. For example, they lacked knowledge of legal cases which had set precedence as to when DoLS should be considered. By not understanding when potential DoLS were occurring people's human rights were not being protected.

Systems were either not in place or robust enough to demonstrate DoLS were managed in line with current legislation to protect people's human rights. 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.

Staff support: induction, training, skills and experience
● People were not supported by staff who had adequate training, skills or experience to meet their needs and safely deliver care. Examples included medicine management, capacity and consent and moving and handling, where training had not been effective.
● Staff raised concerns with us about the lack of training and support they had received. Some were brand new to care or completing apprenticeships. One staff member new to care told us they had only recently begun the Care Certificate despite having started working over a year ago at the service. The Care Certificate is a set of training to ensure staff in health and social care have the knowledge to work in care.
● When training needs had been recognised by the management there was training which lacked reflective practice. Therefore, it had not had the desired impact of changing behaviours of staff members. For example, the registered manager had updated staff around pressure care. Further issues were found in relation to this at the inspection leading to people being placed at risk of harm.
● The provider had an induction in place for all new staff. However, these had not always been implemented effectively at the home. One staff members staff file had an incomplete induction form in. Other staff told us they missed key parts of training due to the home not having the acquired experience on site. For example, practical moving and handling sessions. One staff member said, "Staff are not trained well enough. Many are new to care."

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not in place at the home. This placed people at risk of harm and poor care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People received care and support that was not always in line with current evidence-based guidance. Examples were found around pressure care, catheter care and moving and handling. Care plans lacked details which would be part of best practice to provide detailed guidance for new, inexperienced staff and agency staff to ensure safe and high quality care.
● Staff reviewed people when they recognised changes had occurred. One relative told us, "There was a [virtual] assessment done by someone on behalf of Carrington. [Person] was present." However, care plans

were not always updated in line with changes made. For example, one person's dementia had progressed, and their needs had been changed although the care plan did not reflect this.
● People had their needs assessed prior to moving into the home. One relative said, "I contacted Carrington House and they pushed daily to get the care assessment done [for person]. They did it the day before they went in. [Staff] had [the] bedroom ready for [person] and made [them] feel really welcome."

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to eat a healthy, balanced diet. There were mixed opinions about the quality of food offered throughout the day. One person explained how good the breakfast was. However, the person was less positive about other meals. They informed us at teatime they wanted to get their own food because they were not happy with the options despite repeatedly raising concerns about this. Other people and relatives echoed this concern.
● Relatives had mixed views about the food which was offered to people. Comments included, "She looks really well and is putting on weight, so I think the food is OK", "Food is reasonably good", "He loves his food" and, "She does moan about the food, says it is awful, so I take her food in." One relative was very negative about the quality of the food.
● Mealtimes in the dining room were functional and interactions between staff and people were predominantly task based. On the second day of inspection, there was a celebration lunch and staff had dressed the tables differently although not in line with the standards of the provider. People could choose to eat in their bedrooms. Staff again, were functional in how they brought their meals.
● A blackboard displayed the choices for meals that day in the main dining room. No other menus were available in the home. When a staff member helped people choose their food no alternative methods were used to help people communicate their choices. This concern had already been picked up by the provider's quality team on 9 June 2021. Nothing had changed by the second and third days of inspection.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to other health and social care professionals. One person said, "Staff always got the GP or nurse when required" and continued to explain the staff response to their health needs, "Couldn't be better."
● Relatives confirmed this. Comments included, "Recently [person] was not feeling well. They rang me when the ambulance was on its way. They are very good at keeping me updated sort of thing" and, "[Person] had a psychiatric assessment last year as they did not know if they…had dementia." Care plans reflected what we were told.
● However, some health professionals raised concerns that once they had instructed staff, they worried it would not be followed.

Adapting service, design, decoration to meet people's needs
● People could personalise their bedrooms with their personal belongings and pictures. Work was being completed during the inspection to replace curtains and fix a television.
● However, many of the people had memory loss or limited mobility. Little was in place to be dementia friendly around the home. One person who was nearing the end of their life with limited movement spent long periods of time staring at a radiator with little stimulation or anything uplifting to look at.

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

- The home was not well led. Systems were not in place or established to manage people's safety and ensure high quality care was delivered.
- Management audits were not identifying concerns or had not been started. For example, we asked the registered manager the last time they had audited the recruitment folders; they had not. The provider had not been regularly visiting the service to support and drive improvement due to the COVID-19 pandemic. They had been reliant on what they were being told with minimal checks. Between the first and second days of the inspection they completed a quality visit which was triggered by the start of the inspection.
- The registered manager lacked understanding about their role and responsibility. Examples of these were found during the inspection such as safeguarding and around the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The registered manager told us because of the COVID-19 pandemic they have not had a usual style of induction.
- Actions were not taken to rectify known issues. One relative said, "I have spoken to the manager twice. I mentioned a few things to her like communication, and nothing happens." Examples found were in relation to medicine management, pressure care and meal-time options.
- Concerns found during the inspection had not always been identified by the management and provider. For example, distressed people not receiving the care and support required, capacity and consent not being managed appropriately and issues around pressure care.
- Multiple breaches in regulation were found and best practices were not always being followed.
- Staff did not feel supported and lacked guidance from senior management. They explained the registered manager was usually in their office rather than overseeing the home. Comments included statements about the registered manager, "Bellowing" from their office rather than familiarising themselves in the home.
- The provider's policies and procedures were not being followed by staff and the management. For example, in relation to moving and handling, managing safeguarding, capacity and consent and medicine management.
- There was a high turnover of management at the home leading to inconsistent leadership. One member of staff told us since 2009 there had been 14 managers. Five of these had been registered with the Care Quality Commission. One relative said, "They have had a lot of different managers. I am not so happy with that as different managers have different rules."
- Systems to communicate and gather views of people and relatives were not effective. This had led to

inconsistent views from them and a lack of updates which used to exist.

Systems were either not in place or robust enough to demonstrate safety and quality care was effectively managed. This placed people at risk of harm and poor care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection the provider and registered manager were responsive to concerns raised. The provider put an action plan in place immediately to provide additional support to the registered manager, drive improvements at the home and to keep people safe. For example, they brought in members of their quality team and experienced managers to drive improvement. They also changed the management at the service.
● Relatives had mixed views about how good the communication and openness was with them. Comments included, "Communication is very good. They email me regarding changes to visiting arrangements" and "Communication is quite low. They used to send over a bulletin by email, and invited us to relative meetings, but we have not had those for a long time."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People were not receiving care in line with the provider's ethos of treating people with dignity and respect to lead to inclusive and empowering care. Senior staff members who were present recognised this as we talked through issues.
● Most staff were providing functional care to people with minimal personal interaction. One person responded with, "No one has ever asked me before" to an inspector asking if they were well looked after.
● Mealtimes were not a social gathering. On the third day most staff were seen interacting with people in a task-based manner. Staff were seen walking through the room to get something without acknowledging people unless they started the interaction. One person had to get the attention of staff in the dining room to help another person tuck their chair in.
● Staff did not always respond to people calling out from their bedrooms or ringing their call bells. The registered manager told us some people always called out. One staff member was seen entering a bedroom and turning off the call bell without checking why the person had called them.
● The registered manager was not leading by example so staff would understand appropriate ways to interact and support people. For example, not recognising or responding to non-verbal cues given by people.

Systems were not in place to ensure people were consistently treated with dignity and respect. This is a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A few key staff observed demonstrated a calm, caring approach to interacting with people. They demonstrated they were doing their best under difficult circumstances and clearly had a positive relationship with people.
● Relatives had mixed views about the care their family member received. Comments included, "The care [person] gets is wonderful", "I have seen some of them care for [person]. Care is alright" and, "Once I was there and they [staff] bought [person] breakfast in. She went to grab the salt, thinking it was sugar and I managed to stop her. I do not know if the staff would have."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had mixed views of how involved they were with being involved with the home. No resident

meetings had been held during the COVID-19 pandemic. Staff spent little time socially with people talking through their care due to time pressures.

● Relatives said since the COVID-19 pandemic there had been little time or communication about the home compared to before. One relative explained there used to be a bulletin by email and relative meetings. They continued, "We have not had those for a long time." Another relative said that they were meant to receive a call back; a week passed, and they had not heard back.

● Staff had mixed opinions about how they were listened to by the management. One staff member recalled a personal issue and expressed how good the support has been. Others felt not as supported although did commend some of the senior staff for their support and dedication.

Working in partnership with others

● People were supported by staff who liaised with other health and social professionals. The registered manager had been working to improve relationships with some of them including a joint meeting with the district nurses.

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 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not being protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were not in place to ensure decisions were being made in line with statutory guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving safe care and risks were not always being managed to keep them safe.

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 People were not always kept safe from potential abuse. Systems were not in place to ensure people were protected from inappropriate restrictions to their liberty.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate safety and quality care was effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by sufficient numbers of suitably qualified, competent, skilled and experienced staff