Saffronland Homes 2 Limited

Glen Heathers

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Glen Heathers is a care home providing personal and nursing care to 33 people aged 65 and over at the time of the inspection. The service can support up to 52 people.

People's experience of using this service and what we found
People did not receive a service that ensured they were safe and received the care they required.

Safeguarding concerns were not fully investigated and recognised. Medicines management required improvement to ensure it was safe. The home was unclean, cluttered and poorly maintained. Good infection control measures were not being undertaken.

Staffing levels, skill mix and deployment did not meet the needs of people and placed them at risk.

People's care plans and risk assessments did not always contain the information needed to guide staff how to meet their needs and keep them safe. Where risks were known, people did not receive the care and support they required to reduce these risks.

Staff in leadership roles did not always promote the delivery of high-quality person-centred care or act in an open and transparent way. Governance processes were ineffective. When things went wrong in the service, we were not assured these were incidents were analysed effectively, and lessons were learned and applied to reduce the risks to people and ensure their safety.

Following the inspection the nominated individual (NI) for the provider changed and therefore within the body of the report the NI referred to is the previous NI.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 7 May 2021) and there were multiple breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service in March 2021. Breaches of legal

requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve staffing, governance, safe care and treatment and the requirement to notify CQC of certain incidents.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Glen Heathers on our website at www.cqc.org.uk.

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 the safe care and treatment for people, infection control, staffing, medicines, the environment, safeguarding, governance and notifying CQC of incidents.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will 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 local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures: The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Glen Heathers

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 team consisted of an inspector and an assistant inspector. It was also supported by 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.

Service and service type
Glen Heathers 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 did not have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been appointed and we were told they would be applying to be the registered manager. Throughout the report we refer to this person as the manager.

Notice of inspection
This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We 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 10 people who used the service and two relatives about their experience of the care provided. We spoke with eleven members of staff including agency workers. We spoke with the manager and nominated individual (NI). People were not always able to speak with us in depth about the care they received so we spent time observing the support and interactions between people and staff.

We reviewed a range of records. This included seven people's care records and multiple medication 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 were reviewed. We also reviewed the environment and equipment in place.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also referred our concerns to the local authority.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection we found the provider had failed to safely manage risks to people and take action to mitigate those risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough action had been taken to address this concern and the provider remained in breach at this inspection.

- At the last inspection we found risk assessments in place did not provide specific and detailed information about people's needs to help mitigate risks. This remained a concern at this inspection. For example, one person with diabetes had no plan in place to guide staff in understanding the risks of this condition or what they should monitor for. A second person's care plan gave inaccurate guidance about what blood sugar levels reflected a hypoglycaemic episode. This is when a person blood sugar levels are too low and require intervention. A member of staff told us they had received no training about diabetes and was not aware of the risks associated with this condition. The training records reflected that only five of 18 staff had received training and despite requesting records of staff competency assessments associated with diabetes we were provided with none. We were provided with two staff members competency assessments to use an insulin pen.
- For those people at risk of skin breakdown, exacerbated by their incontinence, there was no guidance about the frequency their incontinence aids should be checked and changed. Daily records for people did not reflect these were changed regularly and we observed handover on 16/9/21 when we heard the nurse state that a person's 'pad' had been changed the day before by the day staff. Day staff work from 08:00 am to 20:00 pm. This was said at 08:00 am handover, meaning this person had been left for at least 12 hours with no change of their incontinence aid. Other staff confirmed that regular changes of incontinence aids did not take place because they did not have the time.
- Where guidance was available to staff, we found that this was not always followed. For example, one person's care plan stated they should be supported to change their position every four hours but the records of when this took place did not demonstrate staff did this four- hourly. Staff told us they did not have time to support people to reposition regularly.
- For another person we observed one member of staff using a piece of moving and handling equipment on their own while the person's care plan made it clear they required two members of staff to use this equipment safely. Staff told us people who needed two members of staff to support them, regularly didn't receive this because they were short staffed.
- We observed one person in bed with bed rails in place and up. Bedrails are a piece of equipment used to prevent the risk of falls from bed, however they can pose risks to people and are therefore not suitable to use for everyone. This person had a sign on the wall stating that bed rails should not be used. The manager

confirmed that bed rails should not be used because the person had tried to climb over them in the past. They put the bed rails down, but we noticed that the sensor mat in the person's room had been left under their bed. A sensor mat would alert staff to a person's movement. We were required to highlight this to the manager.

● Other risk were not acted on promptly. One person told us how they had fallen on a few occasions by the bathroom and were unable to access the call bell to request help. They told us they had been told a pendant alarm had been ordered but it had been three weeks and they still did nott have this. The NI told us this had been ordered and we requested to see confirmation of when this order had been placed but were never provided with this.

● We identified concerns where one person had lost a significant amount of weight in a short period of time, there was no record of the discussion held with the persons GP, no change to their plan of care and a senior member of staff and the manager were unable to tell us what action was being taken.

The failure to ensure risks for people were appropriately assessed and acted upon was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider confirmed action they had taken to address the concerns which required immediate action, including but not limited to the repositioning of people, the changing of incontinence aids and the use of pendant alarms.

● At the last inspection we found environmental risks were not managed safely and we continued to find this at this inspection. For example, we found the door to a sluice room containing an unlocked laundry shoot was open and not secure. We found a room which was storing hand sanitiser was unlocked and open. These were issues of concern we had found and reported on at the last inspection. In addition, we found a large radiator cover hanging off the wall. We found a glass wall light shade with a metal strip hanging off the wall in the dining room. Whilst the radiator had been repaired when we visited on the second day the light remained untouched.

A failure to ensure the environment was safe and well maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider confirmed action they had taken to address the concerns we raised about the environment and we were told workmen were in the home undertaking repairs and decoration.

Staffing and recruitment

At the last inspection we found that the provider had failed to ensure appropriate numbers of skilled, competent staff were adequately deployed to meet the needs of people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough action had been taken to address this concern and this remained in breach at this inspection.

● Prior to the inspection we had been told a new dependency tool was being used to help determine staffing levels but the manager confirmed they had not used one since they started at the home, at the end of June 2021.

● People and staff told us that the staffing levels were not sufficient to meet people's needs. Staff also described how they felt a high use of inconsistent agency workers meant they could not provide people with the care they required. Peoples feedback supported what staff were saying.

● At this inspection the service had identified it needed to staff the home with at least one registered nurse on every shift. However, they only had one permanent registered nurse employed and this person only

worked three nights a week. This meant that seven days and 4 nights were covered by agency staff. In the week of our inspection there were a total of eight different nurses over 14 shifts. In addition to this a high number of agency carers were being used and there was also a lack of consistency with theses carers.

● We observed times when the home was short of staff. The manager told us they required three care staff and one nurse at night, but we observed this was not consistently provided. On the first day of our inspection we saw there were five care staff on duty and on the second day there were eight care staff. Staff told us it was not usual for there to be eight care staff on duty and we saw this was the case on the rotas.

● Staff gave examples of how the lack of staff and high use of agency staff impacted on people. They said people were left in incontinence aids for prolonged hours and were not always repositioned in line with care plans. Records we look at confirmed this. Staff said people did not always receive support by two members of staff when they needed this. We observed one member of staff supporting a person with moving and handling when their care plan stated they needed to be supported by two members of staff.

● One person told us, 'The agency staff haven't got a clue. They don't know the people and they don't know the building.' A second person said, ''They're busy. They tell you they're busy and they'll come back and then you don't see them again. I sat in pooh for a couple of hours once." A third person said, "It's understaffed. There's waiting time in the morning. You wait and wait and wait for a wash. You can wait until 12.00 for a wash. I wouldn't mind 10.30 or 11.00. They get us up at 7.00 and then you wait, it's horrible. I'm content to watch telly after a wash. But you wait and then they come in at a rush in a dither and get you ready before lunch. They must keep my name at the bottom of the list. I just want them to come a bit earlier to give me a wash. I wouldn't think that was a big deal." A fourth person told us, "'I'm told 'We haven't got the staff.' If I had a pound for every time they said that, I'd be a multi-millionaire."

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

Following the inspection, the provider confirmed action they had taken to address some of the concerns we had regarding staffing. This included assurances about consistent agency workers, a reassessment of staffing levels and a review of the deployment of staff.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections.

● We were not assured the provider had effective systems to assure themselves that they were preventing as much as possible the entry of COVID-19 into the premises. The provider was using a number of agencies workers to provide care and support to people living at the service. Agency workers are not employees of the provider and can work at other services. In March 2021 the government introduced workforce restrictions in order to limit the transmission of COVID-19 across care services. This meant that providers should introduced certain measures to minimise the risk. This was not taking place at Glen Heathers. Agency workers confirmed they had worked in other care homes within the previous 10 days. They confirmed that when arriving at Glen Heathers no one had checked them for symptoms of COVID-19 or checked that they had received a negative lateral flow test (LFT) before allowing them to enter the building and work with people. On the first day of our inspection, we were required to ask the manager if they wanted to see our lateral flow test results because we had not been asked for these. On the second day of the inspection no one asked us if we were symptom free or checked out temperatures. On the first day of our inspection we were in the nursing station when a relative approached the member of staff and said they had followed someone else into the building and did someone want their LFT results. They had not been asked for these before entering the home increasing the risk of infections going undetected and spreading.

● A number of areas in the home were unclean and very cluttered, increasing the risk of the spread of infection. We raised this with the NI on the first day of our inspection. However, despite this we continued to

find the same areas cluttered and unclean on the second day of our inspection.

A failure to ensure effective infection prevention and control measures and a clean environment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Following the inspection the provider confirmed action they had taken to address the concerns which required immediate action, including providing assurances about the processes for staff to follow when agency workers, visitors and other professionals enter the home.

Using medicines safely

● Medicines were stored in locked trolleys in locked rooms. The temperature of medicines storage rooms was checked daily. The temperature of the medicine's fridge was also checked daily but this was often recorded as being out of the recommended range and we could see no action that had been taken. In addition, the fridge was continually sounding an alarm, which we were told had been happening for some time but the member of staff was not able to explain why.

● Medicines records were mostly complete, and we did not find high numbers of gaps in medication administration records (MARS). However, where there were gaps in MARs there was no recorded explanation and we were therefore not assured about whether the medicine had been given as prescribed.

● Where people were prescribed medicines that posed risks, such as those that thin the blood, we found no information available to staff to guide them to this risk. We observed new agency workers were not given time to read care plans but were provided with handover sheets, however this information was not on the handover sheets. When we asked a member of staff who administered medicines, what the risks of one of these medicines was, they told us they did not know.

● Information available to staff about 'as required' medicines for three people whose records we looked at was misleading. We found protocols were in place providing information to staff about the use of certain medicines on an as required basis, but these medicines were prescribed to be given as regular doses to people increasing the risk of medicine errors occuring.

● For one person we found they had been prescribed a cream which posed risks if used for prolonged periods. The instructions on the medicines administration records clearly stated this should be applied twice a day for no longer than 5 days per week. However, the records showed this had been applied for 27 consecutive mornings, eight and then 10 consecutive afternoons, meaning this had not been applied as prescribed.

● The provider was using registered nurses from an agency who were required to administer and manage medicines. However, they had not undertaken any assessment of these workers competence to perform this task safely.

A failure to ensure medicines were managed safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff we spoke with had a good understanding of their responsibilities in relation to safeguarding people and they were aware of how to report concerns, although they felt concerns were not listened to and acted upon by the management of the service.

● Prior to the inspection we received feedback from the local authority who had expressed they were concerned that safeguarding matters were not investigated appropriately, and they were not provided with sufficient evidence to be able to conclude that allegations were or were not substantiated.

● We were not confident safeguarding matters were recognised by management or that these were investigated thoroughly. For example, we were made aware of a number of safeguarding enquires that the

local authority had requested the manager and NI to investigate. We requested to see the full internal investigation records on multiple occasions and were not provided with these. We were provided with a report the local authority had requested for one allegation of abuse. This had been completed by the NI but did not reflect an investigation, supporting evidence, outcome or lessons learned. In addition, the NI sent us copies of email discussions with the local authority regarding a further allegation of neglect made by a professional, in which the NI described the concerns as 'childish' and 'petulant' and the response provided to the local authority did not reflect the concerns raised had been investigated and acted upon.

A failure to ensure effective systems were in place and operated to investigation allegations of abuse and safeguard people from abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection a senior manager for the provider confirmed they would be reinvestigating all the concerns raised and moving forward all investigations would be completed by either them or another member of the senior management team.

Learning lessons when things go wrong

- We were not confident when things went wrong lessons were learned. We asked to see records of an investigation into an unexplained injury reported on the managers monthly report for July 2021 and we not provided with this. We looked at records regarding investigations into safeguarding matters and could not see this identified any lessons to be learnt or taken forward. The manager told us audits of things such as complaints, safeguarding and incidents did not take place and as such we were not confident that themes and trends were looked at. Staff told us discussions about lessons learned did not take place.
- We were unable to see action taken as a result of our last inspection where we identified and reported on concerns. We had been provided with an action plan from external professionals following visits from them which contained recommendations and could not see how this had been acted upon. For example, the action plan stated that 'Risk not always adequately documented within care plans.' As detailed above we continued to find this, meaning we were not confident that lessons had been learned and acted upon.

A failure to ensure systems and process were in place and operated effectively to learn lessons and drive improvement to the safety and quality of the service was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At the last inspection we found multiple breaches of the regulations. At this inspection we found these breaches remained and a further breach was identified. This demonstrated a lack of effective action had been taken to drive the improvement required.
- The manager was unable to demonstrate an understanding of their role and what was required of them. For example, we found there was a lack of evidence that learning from incidents and accidents had taken place, to drive quality and safety at the service. In addition, we identified occasions when the provider had not complied with a requirement of their registration, to notify CQC about significant events without delay. This was a breach at our last inspection. We discussed this with the manager who said the incidents they were unaware that these incidents needed to be reported to CQC. A failure to notify CQC limits our ability to perform our regulatory duty of monitoring events that occurred at the service.

The failure to notify CQC was an ongoing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- The manager appeared to lack an awareness of what was happening in the service for people. For example, we asked them what the outcome of a GP discussion was following a significant weight loss over a short period of time for one person. They were unable to answer and said they would look into it. They then told us the person had been started on supplements, but we found they had not been prescribed and a senior member of staff told us the person was not on any supplements.
- The manager told us that they did not understand the expectations of the role. They had been moved from another of the provider's homes to this one when the last manager left but had not had the role clearly explained.
- There was a lack of oversight of the service by the NI. They told us agency inductions took place and that there was a competency framework used for agency staff. However, the manager was unaware of this and confirmed that no competency assessments of either agency registered nurses or carers was completed. The NI was not aware of this demonstrating they lacked oversight of this process.
- The provider required monthly reports to be completed by managers. This involved a review and audit of multiple areas of the home, including but not restricted to incidents, falls, weight loss and care plans. The NI had completed this with the manager for July 2021 and emailed it to us before the inspection. This lacked detail and we were required to ask further questions which the NI did not fully answer. We asked to see the report for August 2021, and this had not been completed. The director of operations told us the manager

had not been asked to do this and it was the responsibility of the NI to complete. However, they were unable to provide us with this.
● We requested to see copies of complaints audits, safeguarding audits, incident and accident analysis and the manager confirmed these were not in place and they had not completed any since they started in the home.
● The medicines audit completed the week before our inspection had not identified the concerns we had found and was therefore not effective.
● The health and safety audit we were provided with was dated May 2021 and had not identified the concerns we found regarding the environment.
● Prior to the inspection the NI sent us a copy of their action plan which they confirmed on the first day of our visit this was the most current and up to date. This stated that 'All notifications are overseen by SMT and copies maintained. (NI) and manager are ensuring all sent appropriately. Investigations have ensured actions taken to prevent further incidents. Audit information now being used as planned. Interim manager now aware of the depth of information to be completed.' It also stated that improvements to care plans has been made. Throughout this report we have documented multiple concerns that demonstrate the action plan was not accurate. We have found and reported on multiple concerns regarding the safety, quality, leadership and oversight of the service.

The failure to operate effective systems to assess, monitor and ensure the safety and quality of the service was an ongoing breach of Regulation 17 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
● People in leadership roles did not always promote the delivery of high quality person centred care. Staff told us they did not all enjoy working at the service and felt they did not have enough time to meet people's emotional and physical needs. One staff member told us they are told by management 'its 24-hour care so if one shift doesn't get time another will'. This staff member said, "It's not good enough when they [people] need help now." Staff told us they felt there was no leadership, no organisation, they were not listened to and issues of concern were swept under the carpet. They lacked confidence in the management of the service. They said the manager and nominated individua (when in the home) spent the whole time in the office and were not visible to staff. We observed this on our second day of inspection.
● Feedback from people about the service they received was not always positive. One person told us, "I don't know why they take it out on me. I ask if I can go to the toilet. I can do it in the bed, you know and not make a mess, but I don't want to, and I wait and wait. Some of them, not all of them are rude to me. One of them particularly is like I'm making a nuisance of myself. I thought it was nice at first, but now I wish I was gone, I wish I was dead and then I wouldn't have to put up with it. I'm so unhappy." A second person said, "I don't like the home. I think it's a dump. I don't like the place. There's nothing to do. There's nothing for us. I sit here all day doing this [reading the newspaper.] There's nothing for us to do."
● There was a lack of care, attention and action shown by leadership staff. On the first day of our inspection we walked the NI around the home to show them the environmental areas of concern we had found and the areas which required cleaning. This included broken wall lights, unclean areas, stained carpets, broken window handles and door guards sounding an alarm.
● One person told us, "The wall light is hanging off the wall in the dining room, it's been like that all the time I've been here."
● We continued to find areas that could have been addressed promptly had not been acted upon. For example, multiple bedroom door guards' alarms were sounding when we arrived on the first day of the inspection. These alarms were sounding because the batteries needed to be changed. On our second day of

inspection, three days later, these alarms were still sounding. We addressed this with the manager who told us the batteries had not been changed because maintenance was responsible for doing this, however records showed these had not been reported. Approximately 10 minutes after our discussion with the manager we observed him changing the batteries in the door guards. We were not confident that these would have been changed if we had not addressed this at the time. No one had acknowledged this, it was a simple task to undertake and no one appeared to acknowledge the impact this noise could have on people who were in the rooms.

A failure to ensure the environment was safe and well maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On another occasion we observed that a person's bed had been pushed against a wall which had caused it to lift and be perched on the skirting board at one end. In addition, the brakes were not on. No one had noticed this and if the person had tried to get into bed could have placed them at risk. We moved the bed and put the brakes on to make this safe.
● Another person said, "There's a pull cord in the dining room and in the toilet but in this [living] room, no. They go for breaks and sit there when you want help." Another person when asked if staff were caring and compassionate said, "Yes. They were when I cried yesterday. I was still in bed at quarter to 12. I like to be up at 10 am. But everyone wants to be up early. There are staff shortages, it's difficult. They do the best they can." One person told us, "There are some very, very good carers, but others don't bother. Some are very pleasant. One of the overnight staff will do anything for you. He says, 'Will that be all, Ma'am?' It makes you feel like the Queen."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us they did not feel listened to and said they had been raising their concerns about staffing with management for some time. We saw this had been raised in a feedback survey in March/April 2021 by staff and we continued to find concerns regarding staffing at this inspection.
● No meetings had been held with people or their relatives to seek their feedback. However, a feedback survey had been undertaken in March/April 2021. We were not assured that feedback comments were explored, and appropriate action taken. For example, one person had fed back, 'More staff needed - the staff you have are excellent.' The comment from the service about this was 'Levels are reviewed regularly to ensure sufficient numbers maintained.' However, we found concerns about staffing levels during our inspection in March 2021 and again at this inspection. Another person had commented 'More entertainment, more men to talk to, more time so I can go out of the building'. No comment to this had been made by the service and no action planned.

A failure to ensure feedback is appropriately acted upon was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The local authority and care homes team had been working with the service prior to our inspection. The local authority expressed to us concerns about a lack of detailed responses to safeguarding concerns and felt there was a lack of improvement being made. The care homes team shared a copy of their recommendations to the home which we were not confident the service had acted upon. Following our inspection, the local authority and care homes continued to provide support to the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify CQC of significant events, in line with the requirements of their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person failed to ensure effective systems were in place and operated to investigation allegations of abuse and safeguard people from abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person failed to ensure the environment was safe and well maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to ensure effective infection prevention and control measures and a clean environment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person failed to ensure medicines were managed safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
Treatment of disease, disorder or injury	The registered person failed to ensure risks for people were appropriately assessed and acted upon was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

A warning notice was served for failures to ensure risks to service users were assessed, plans were developed to mitigate the risks and staff adhered to guidance. The provider was required to meet the requirements of the regulation by 2/11/2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person failed to operate effective systems to assess, monitor and ensure the safety and quality of the service was an ongoing breach of Regulation 17 of the health and Social care Act 2008 (regulated Activities) Regulations 2014. The registered person failed to ensure systems and process were in place and operated effectively to learn lessons and drive improvement to the safety and quality of the service was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to ensure feedback is appropriately acted upon was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

A warning notice was served for failures to ensure effective governance systems were operated to ensure the safety and quality of the service. The provider was required to meet the requirements of the regulation by 30/12/2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person failed to ensure appropriate numbers of suitably skilled and experienced staff were effectively deployed to meet the needs of people.

The enforcement action we took:

A warning notice was served for failures to ensure suitable numbers of skilled and competent staff were deployed at all times. The provider was required to meet the requirements of the regulation by 2/11/2021.