The Seymour Home Limited

Seymour Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service

Seymour Care Home is residential care home located in East Manchester. The home is registered with the Care Quality Commission (CQC) to provide personal care and accommodation for up to 27 people over the age of 65, including people living with dementia. At the time of the inspection there was 21 people living at the service.

People's experience of using this service and what we found
People were not supported safely. Risks to people were not always robustly assessed and mitigated. Medicines were not safely managed. Staff were not recruited and deployed safely and effectively.

People were not always treated with dignity and respect. We observed one person who became very distressed being left by 3 members of staff. Support around mealtimes was sometimes undignified, with some meals returning to the kitchen uneaten. There were times, the communal areas were very loud and not always favourable for people living with dementia, on one occasion a person had their fingers in their ears as it was so loud. People were not always involved in planning and reviewing their care.

The providers internal governance processes did not highlight the concerns we found at this inspection. We found training was ineffective at the service. There were concerns in relation to the culture at the service. Mental capacity assessments were ineffective and some in some cases not decision specific. They were not detailed and did not cover how the service had assessed people's capacity. Some people's capacity assessments had not been reviewed for some time.
Records in relation to safeguarding were not robust enough. We have made recommendation about this.

The service worked well with external agencies including district nursing and primary care.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Rating at last inspection and update
The last rating for this service was requires improvement (Published 04 April 2022)

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

At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk, staffing, recruitment, and training. This inspection examined those risks.

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 and Recommendations

We have identified breaches in relation to person centred care, dignity and respect, need for consent, safe care and treatment, governance and oversight of the service, staffing and fit and proper persons employed.

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

Follow up

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

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

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

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

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

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

Seymour Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.
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 2 inspectors and 1 medicines inspector.

Service and service type
Seymour Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Seymour Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who lived at Seymour Care Home about their experience of the care provided and 3 relatives. We spoke with 6 members of staff including the registered manager, deputy manager, senior carers, activities co-ordinator and care assistants.

We reviewed a range of records including 6 care plans. A variety of records related to the quality, safety and management of the service were also reviewed. During the inspection we reviewed 6 medicine administration records and looked at medicines related documentation. We observed medicines administration, checked storage, and spoke with 3 staff in relation to medicines management.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

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

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

At the last inspection, the provider had not done all that is reasonably practical to mitigate risks to people. This exposed people to 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.

Not enough improvement had been made at this inspection and the service remains in breach of Regulation 12.

Assessing risk, safety monitoring and management;
●Risks were not adequately assessed and managed at the service.
●The management of thickener powder, used for people with swallowing difficulties, was not safe. Tins were not always securely stored, staff used the one tin of thickener to thicken people's drinks, rather than the person's own supply. Staff were not recording when thickener had been added to drinks so we could not be sure that this was done properly.
●The necessary health and safety checks, such as gas safety and electrical safety, were completed in line with requirements. However, the legionella risk assessment had expired.
●We also found several radiators in communal areas without covers that were very hot to the touch, one was located next to a dining room table people used at mealtimes and could cause injury. We asked the service to review this.
●Fire safety was not adequately managed. For example, the latest fire risk assessment highlighted several issues that required remedial action, but these actions were not completed at the time of the inspection. We found a fire exit was blocked with equipment while another had chairs behind the external exit, which would restrict evacuation. We requested these obstructions be removed immediately. People's personal evacuation plans did not reflect their current needs and support needed to safely evacuate the building. In addition, the service did not have any equipment such as an evacuation chair to assist in the evacuation of people living upstairs. Fire extinguishers were in locked cabinets and 2 of these had no accessible key. Due to the seriousness of these concerns, we made an urgent referral to the Fire Safety Team at Greater Manchester Fire and Rescue Service and sought immediate reassurances from the provider and registered manager.
● The safety of the premises was not monitored effectively to keep people safe from potential hazards. We found the laundry door was unlocked on multiple occasions. This placed people at risk of harm as it contained several potential safety hazards. We also found the COSHH cupboard open and unlocked, which contained hazardous substances.
● We had to intervene during the inspection, when a person was mobilising without any mobility aids despite their care plan stating they required a zimmer frame and risked falling. Staff failed to recognise the risks associated with the person trying to mobilise without their simmer frame.

Systems were not robust enough to demonstrate risks to people's safety were effectively assessed, managed, and mitigated. This placed people at risk of harm. This was a breach of Regulation 12 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

●Medicines were not always managed safely. For example, we found time sensitive medicines were administered late for 2 people, in addition, staff did not record the times of any time sensitive administration, to ensure doses were not given too close together.
●Medicines given covertly (hidden in food or drink) were not managed well. There were no clear instructions to guide staff how each person liked to have their medicines, or specific information from healthcare professionals on how medicines should be hidden. One person who lacked capacity was not observed by staff taking their medicine properly and we later found the tablet on a table in a communal area.
●Guides for staff to administer medicines when required were not always accurate or person centred. For example, it was not clear whether 1 or 2 tablets should be taken, there was no information regarding a gap between doses where necessary and no information about why the medicine was prescribed.
●MAR charts for topical medicines were signed by senior staff when they had not administered them. Staff told us they signed 'on behalf' of the carers who applied the creams, even though they could not be sure that this was done.
●Medicines were not stored securely. All staff had access to the medicines room and during the morning medicines round the trolley was left open and unaccompanied in the room. The medicines fridge had been out of temperature range with no action taken and the fridge was not exclusively used for medicines. Deliveries were stored in an additional room that was not temperature monitored. Returns were not secure or adequately documented. We also found first aid medicines that were out of date.
●We did not see evidence that staff's competency was to administer medicines was regular checked. Staff who did the checks did not provide evidence that they were competent to assess others. Completed medication audits demonstrated a lack of knowledge and understanding as responses were not always accurate.
●Medicines policies and procedures did not provide enough information for staff to manage people's medicines safely. This included safe ordering and storage processes, administration, and audits.

The provider failed to ensure medicines were safely managed. This exposed people to a 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.
Systems and processes to safeguard people from the risk of abuse
●Systems and processes to protect people from the risk of abuse were in place however the service needed to review training and internal investigation minutes.
●Not all staff had received safeguarding training. Those that had, last attended safeguarding training in 2021, this training was combined with other training courses at the same time. This is reported on further in the effective domain.
●We reviewed 1 recent safeguarding and found investigation records to be unclear and illegible in some parts, although we were informed of the outcome there was no clear outcome from the local authority.
●The service made referrals to the appropriate agencies, such as CQC and the local authority.
●Staff told us that they believed that any concerns they raised with managers would be dealt with appropriately.

Records in relation to safeguarding were not robust enough. We are recommending that the service improves the robustness of the recording of internal safeguarding investigations.

Staffing and recruitment;

●Staffing levels were not managed safely. The service didn't always deploy staff effectively. One staff member told us, "It feels like there isn't enough staff, 3 on the floor just isn't enough". The service could not tell us how their dependency tool linked to staffing numbers, this meant there was no clear system to identify when staffing needed reviewing.

● Staff appeared very task orientated and rushed. For example, on 2 separate occasions we saw staff delivering personal care without the relevant PPE. On another occasion staff forgot to put the brake on a wheelchair and tried to support someone out of the chair, although no harm was caused to the person this placed them at risk of harm.

●Despite a physical move in one manager around the building there still wasn't visible leadership on the floor, this meant there was missed opportunities to identify the issues we had found on this inspection.

●One person received 1:1 support however, during the course of the inspection, the member of staff assigned to this person was on the floor, leaving the person without the necessary level of support.

●One person also told us, "I was offered a drink ages ago, I'm still waiting for it."

●We had to intervene during the inspection when 3 members of staff left a person in distress.

●The service employed two activity coordinators; however, these were dual carer roles. We found during the inspection these staff members were often pulled into providing care and support to people.

●People who smoked were often locked out of the building and could not get back in due to codes on the door. This included people who were subject to Deprivation of Liberty Safeguards authorisations. On multiple occasions across both days, inspectors had to let people back into the building, due to a lack of staff monitoring and management. When outside there was no staff supervision, and this placed people at risk of harm.

The provider had failed to deploy sufficient numbers of staff to make sure they could meet people's needs. This placed people at risk of harm. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment was not safe. Staff had gaps in working histories that were not explored by the provider. We also reviewed one staff member's file that did not contain proof of identity, as is required. .

●The provider could not be sure new staff had the skills, experience and competency for the roles they were being employed for due to a lack of formal interviews. For example, we found no records of interviews being conducted with staff who had recently started at the service. A large proportion of staff had not been employed in care roles before.

The provider had not ensured recruitment systems were operated effectively to ensure staff were fit and proper to carry out their role. This placed people at risk of harm. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

●Not enough work had gone into educating staff on closed cultures considering there was some longstanding concerns in relation to some elements of the culture at the service.

●Staff told us they knew how to raise concerns and felt comfortable raising concerns.

Preventing and controlling infection

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

● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.

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

● We were not assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.
●The service was operating a temperature checking process at the home however we could not be assured that the equipment was calibrated to give accurate readings, as some readings were out of range for visitors.
● On 2 occasions we saw PPE not being used in line with guidance, which placed people at risk of infection.

Visiting in care homes

The provider was facilitating visits for people living in the home.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills, and experience

- The registered manger told us the induction process for new staff was 3 days. However, records showed us, and staff told us this was often shorter.
- There was high usage of agency staff at the service who didn't always receive an induction. One staff member told us, "If it's a new staff, this makes it difficult, we have to pair them up with a member of staff, there is no induction if we are short staffed"
- The policies and procedures for training were not clear in expectations for what training staff needed to complete. On the first day of inspection the training matrix hadn't been updated and included staff members who had left the service. It also didn't contain the details of a number of new starters, so it was unclear how the provider and registered manager ensured staff received appropriate training and relevant refresher training.
- Training had not been completed for a large proportion of staff in areas such as equality and diversity, end of life and continence care. Training was also not provided in key areas including learning disabilities, epilepsy, and diabetes management despite people at the home having needs in these areas.
- A large number of staff had not been enrolled in any formal training in health and social care such as the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme
- Staff we spoke with felt well supported in relation to supervision and felt staff morale was okay.

The provider had not ensured staff were supported to have the right skills, knowledge and understanding to perform their roles. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Support at mealtimes was not always dignified.
- We observed a number of people who went without support at mealtimes, and in some instances, meals were returned to the kitchen hardly eaten. When reviewing care plans these individuals required support and prompting at mealtimes, we observed no support being provided due to staff being rushed at mealtimes.
- People's dietary requirements were not always managed appropriately, we report on this further in the Responsive domain.

●The service employed a kitchen manager who was responsible for meals at the home, meal consistency information was displayed in the dining room and there was a sheet that recorded allergy information.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●People's healthcare needs were being met. Records showed referrals were made to the dentist, GP and community nursing services when required

Adapting service, design, decoration to meet people's needs
●Pictorial signage was used to help people find bathrooms and communal areas, as a number of residents had a diagnosis of dementia.
●There was a lift and mobility equipment available for people who needed it.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

●Mental capacity assessments within people's care plans were ineffective and sometimes not decision specific. They were not detailed and did not cover how the service had assessed people's capacity.
●Some capacity assessments had not been reviewed for people in a significant period of time.
●Best interest decisions often did not involve the individual.
●The service made necessary referrals for DoLS, for people living at the home.

The provider did not ensure consent was gained for care and treatment from the relevant person. Mental capacity assessments were not detailed, and best interest decisions were not reviewed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance, and the law
●People's needs were assessed prior to their admission to ensure their needs could be met. Information was sought from the person, their relatives and from care professionals.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for, or treated with dignity and respect.

At the last inspection, the provider did not do everything reasonably practicable to make sure people were treated with dignity and respect. This was a breach of Regulation 10(Dignity and Respect). At this inspection not enough improvement had been made and the service remained in breach of Regulation 10.

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

- People were not always supported in a dignified manner. Support from staff was task focused This limited the ability to engage meaningfully with people who used the service.
- We observed periods across both days in communal areas and found that staff did not always interact with individuals in a compassionate manner. This included standing over people when speaking to them or rushing some interactions.
- Some people's daily notes were illegible which made it difficult to determine what care was provided.
- One person's care plan stated that staff should assist and ensure that facial hair is removed when showering and bathing however inspectors found the person hadn't been assisted with this and looked unkempt.

The provider failed to ensure people were treated with dignity and respect This was a breach of Regulation 10 (Dignity and Respect).

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

- Care plans did not demonstrate how people were involved in decisions about their care, we report on this further in the Responsive domain.
- We did see examples of 'resident 1 to 1 meetings' taking place to discuss menus and activities, however, it was not clear how this information fed into improvements at the service.
- The service did work with the advocacy services where required

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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

- Care planning was not robust, with some care plans containing conflicting information.
- Care plans for oral health had the same support required for someone who has scored low risk and someone who had scored high risk, meaning care was not personalised to the person's level of need.
- We found staff did not always follow guidance in people's care plans around the support people required with eating and drinking.
- People were not supported to develop and maintain relationships or take part in activities that were relevant to them.
- The service employed two activity coordinators; however, these were dual carer roles. We found these staff members often got pulled into providing caring as opposed to delivering activities.
- People were sat in the lounge for large parts of the day listening to music. On day 2 of the inspection the music was so loud 1 person had their fingers in their ears. Music playing was not selected by people who use the service.
- One person told us, "I'm sick of it here, there's nothing to do, you get up, sit in here, there's no one to talk to, you don't get help." Another person told us, "It's boring, nothing to do, not a lot, really honestly nothing."

The provider failed to ensure people received person centred care, reflective of their individual needs and preferences, this was a breach of Regulation 9, Person-centred care

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

- Information was made accessible for people who used the service.
- Signage was used around the home to orientate people to their rooms or bathrooms.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy in place.
- The provider dealt with complaints that were raised effectively.

End of life care and support

- End of life care plans lacked detail and were not person centred.
- The palliative care procedure for the home references procedures around end-of-life pathways which have been phased out.
- Only 2 members of staff had received specific training around end-of-life care for those with dementia and the training matrix showed no other end of life care training had been made available to staff.
- The service was not supporting anyone at end of life at the time of the inspection.

Inadequate

Is the service well-led?

Our findings

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

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

At the last inspection we identified issues around governance and oversight. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the service remained in breach of Regulation 17.

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

●The service had not taken sufficient actions to address concerns raised at previous inspections.
● The provider and management team at the home were not clear on their roles and responsibilities. Following the last inspection, the provider submitted an action plan to CQC detailing how concerns identified would be addressed. At this inspection large portions of this action plan were marked as completed; despite the significant number of issues, we have found at this inspection. There was also a lack of provider and registered manager oversight of risk, which we have reported on in the safe section of this report. One staff member told us when asked about manager visibility, "I don't know, I can't see downstairs, [the registered manager] comes when she sees something on the camera, other than that, we don't see her.". At the last inspection we recommended a review of the leadership and management at the home, but this had not been completed.
● The services audits were basic and lacked robustness and detail. They failed to identify the issues we had found at this inspection in relation to risk, oversight of medicines, staffing, recruitment, training, mental capacity, providing person centred care and ensuring people were treated with dignity and respect
●Records indicated there was a lack of team meetings with staff.
●Following our last inspection, the provider had appointed an external quality consultant to support improvements needed. The registered manager could provide us with no details of how the external quality consultant had been working to ensure improvements were made at the service. Portions of provider's improvement action plan were assigned to the external consultant to review but there was no evidence of any improvements following this intervention.
● We found policies and procedures were generic, undated, and it was not clear when and how they were reviewed. We noted that the end-of-life policy referred to practice no longer followed.

The evidence outlined above demonstrates systems and processes for good governance were not operated

effectively. 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

● At our last inspection we made reference to the culture at the home and concerns dating back to October 2020, indicating a potential closed culture at the service. At this inspection we found continued poor practice which when coupled with poor leadership, a lack of staff training and experience, a lack of positive engagement with people who use the service and staff are all indicators of a closed culture within the service.

●The Provider, Nominated Individual and Registered Manager appear over reliant on monitoring the service via CCTV.

●During the inspection we noted one of the cameras appeared to have been moved, limiting the area being monitored, we fed this back to the registered manager to investigate.

●The Registered Manager was unclear as to the remit of the CCTV around audio recording with some conflicting information documented around this. There was no audit trail of CCTV access, with one manager referring to checking the CCTV from home.

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

●The home had been honest and open when things had gone wrong, including around a recent serious incident. However, more widely, given the ongoing concerns in relation to the culture within the home and concerns in relation to poor practice, we could not be assured that the service had created an environment where people could be honest and transparent.

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

●The provider had requested feedback from staff and people about the home, however the registered manager had limited oversight of this feedback, as it returned directly to the provider. It was not clear how many people had provided feedback. The service had recently completed 1 to 1s with people who use the service to discuss activities and meals.

●Staff feedback had been completed however only a small number of staff had returned their feedback.

●The service notified CQC of incidents that they were required to.

Working in partnership with others

●The home worked well with local health providers including GP's and district nursing teams.

●The home was working with the quality team from the local authority.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received person centred care, reflective of their individual needs and preferences, this was a breach of Regulation 9, Person-centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect This was a breach of Regulation 10(Dignity and Respect).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure consent was gained for care and treatment from the relevant person. Mental capacity assessments were not detailed and best interest decisions were not reviewed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014