Aden House Limited

Aden House Care Home

Inspection report

Long Lane
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Huddersfield
West Yorkshire
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Tel: 01484866486

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

Summary of findings

Overall summary

About the service
Aden House is a care home providing personal care for up to 60 people. At the time of our inspection there were 34 people living at the service. There are communal areas and accommodation on both the ground and first floor. The Butterfly unit on the ground floor supports people living with dementia.

People's experience of using this service and what we found
There were not enough staff deployed at the service to meet or respond to people's needs safely and effectively. The environment was unclean, in a state of disrepair and was not dementia friendly. Risks associated with infection prevention and control (IPC) were not effectively managed. Risks to people's safety were not adequately assessed, monitored or managed. Medicines were not managed safely.

The service was working within the principles of the Mental Capacity Act (MCA) and appropriate legal authorisations were in place when needed, to deprive a person of their liberty. Policies in the service supported this and staff supported people in their best interests, in the least restrictive way possible. However, people were not supported to have maximum choice and control of their lives. People's care was not delivered in line with their needs and preferences and their personal care needs were not always met. People's privacy and dignity was not consistently maintained. Staff did not always speak to people in a way that was respectful. People did not always have fluids readily available to them.

Staff did not always complete relevant training to ensure they had the right skills and knowledge to support people safely. Appropriate support was not in place for staff. Care records did not contain an accurate overview of people's care and support needs. They were not person centred and were often incomplete. There was a lack of engagement and activities for people.

Shortfalls identified at the previous inspection had not been addressed. Systems and processes to monitor and improve the quality of the service were ineffective as they had not identified issues found at this inspection. Where issues had been identified, no action had been taken to improve the quality of the service. Incidents were not always reported appropriately. There was no oversight with regards to reporting, analysing and learning from incidents. Effective systems had not been established for gathering feedback from people and relatives. The provider did not always effectively work in partnership with other agencies as a means of improving the quality of the service.

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 01 July 2021) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvement had not been made and the provider remained in breach of regulations.

At our last comprehensive inspection (published 17 September 2019) we recommended the provider consider current guidance in meeting the requirements of the MCA. At this inspection we found the provider was now meeting the requirements of the MCA.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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.

During this inspection, we also checked whether the provider had followed their action plan to confirm whether they now met legal requirements.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

Enforcement and Recommendations
We have identified breaches in relation to managing risks to people, infection prevention and control (IPC), medicines management, staff numbers, support and training, record keeping, person centred care, and oversight of the service.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Aden House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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, 1 medicines inspector and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Aden House 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. Aden House is a care home registered to provide nursing care. However, at the time of inspection, there was no nursing care being provided. 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 not a registered manager in post. The registered manager had recently left the service. The regional manager was providing cover until a new manager could be recruited.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority, commissioners and Healthwatch Kirklees. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 of this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 4 relatives about their experience of the care provided. We spoke with 13 staff members including the regional manager, deputy manager, carers and domestic staff. We spoke with 1 healthcare professional who worked with the service.

We reviewed a range of records including 6 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and supervision. We reviewed records relating to the management of the service, including policies and procedures and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had not ensured safe assessment, monitoring and management of risks to people's health which increased the risk of harm. This was a breach of regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people's health were not safely assessed, monitored, and mitigated. For example, risks associated with falls, pressure damage, dehydration and choking.
- People's pressure care risks were not managed safely. For example, 1 person's care records said they should be repositioned 2 hourly and not seated on their bottom. On 3 occasions we found this person seated on their bottom. Repositioning records showed they were also not being repositioned 2 hourly and were being left seated on their bottom.
- Systems were not in place to ensure staff understood people's risks and needs. For example, staff were not aware of a person's choking risk. We found this person was left unsupervised with a meal, and not sitting in an upright position, placing them at increased risk of choking.
- Where equipment was required to ensure people's safety this was not always in place. For example, 1 person was immobile and assessed as being high risk of falls. This person had no call bell or falls sensor mat in place to alert staff in an emergency. On the first day of inspection, we found this person shouting "help me" repeatedly from their room. Staff did not respond until alerted by the inspector.
- Accidents and incidents were not always recorded and appropriately reported. Systems in place were not effective in identifying lessons learned and mitigating future risks.

The provider failed to ensure safe assessment, monitoring and management of risks to people's health. This placed people at risk of harm. This was a continued breach of regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection risks in relation to IPC were not always effectively managed. This placed people at increased risk of harm. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risks relating to infection prevention and control were not effectively managed.
● The service was unclean and in a state of disrepair. We found dirt and debris on floors and surfaces. Seats in some communal areas were stained and wooden handrails were chipped.
● Communal bathroom facilities were not always clean and safe to use. For example, we found rusty plugholes in sinks, dirt around toilet areas, loose toilet seats and a discarded broken tissue dispenser. Soap for handwashing was not always available, and some hand gel dispensers were empty.
● Procedures for safe waste management disposal were not always followed. For example, we found a clinical waste bag left in a bathroom next to a full clinical waste bin. Some bins had no lids.
● People's bedrooms were not always clean. Side tables were stained, and bedding was not always clean and was ill fitting. En-suite facilities had stained cabinets containing dirty toiletries, hairbrushes and toothbrushes. We found 1 person had no lid on their toilet seat.
● Equipment was not always clean. For example, 3 people's falls crash mats were dirty with debris on the surface.

The provider had failed to ensure risks in relation to IPC were effectively managed. This was a continued breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had not ensured the proper and safe management of medicines. This increased the risk of harm to people and the potential for medicines errors. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not always managed safely. This placed people at increased risk of harm.
● People did not always receive their medication as prescribed. For example, 1 person's topical medication administration record (TMAR) showed they had not had their cream administered to their legs on several occasions. This person was found to have dry and shedding skin on their legs.
● Guidelines for the administration of medicines, including as required (PRN) medications, were not always in place or were not clear. For example, there were no instructions on 1 person's electronic medication administration record (eMAR) or medication label regarding the administration of their medicated cream. Therefore, staff did not know where it should be applied. A further 2 people did not have protocols in place for their PRN medications, to explain to staff what the medicines were for and when they should be given.
● Records relating to medicines were not always fully complete or accurate. 7 people's eMAR's contained recording errors and omissions. For example, 2 people did not have their allergy status recorded and 1 person's medication stock counts were incorrect.
● The provider did not always follow their own policy regarding medicines management. This was in relation to staff access to the electronic medication records and the disguising of covert medicines.

The provider had failed to ensure safe management of medications, placing people at risk of harm. This was a continued breach of regulation 12 (2) 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 in place did not always protect people from the risk of abuse.

● Incidents of a safeguarding nature were not always identified or reported to the required agencies. For example, we found 6 incidents which had not been reported to the local authority safeguarding team or CQC.

● Care records for 1 person had not been updated following 6 incidents of a safeguarding nature.

The provider had failed to do all that was reasonably practicable to mitigate risks to people as a result of safeguarding incidents. This placed people at risk of harm. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff deployed to meet people's needs safely, placing them at risk of harm.

● Staff were not always available to meet people's needs in a timely manner. For example, 1 person was in a communal area in a state of undress. There were no staff in the area to assist and there was a delay of approximately 2 minutes in attending to them. We also found people were still being washed and dressed for the day at midday.

● Staff were not always able to meet people's assessed needs adequately. For example, 1 person required one to one support from staff. However, we found the staff member allocated to support this person also supporting another person at the same time.

● Feedback from staff was consistently negative regarding staffing numbers. Staff told us, "Between trying to do personal care we have nobody watching [people] when [staff] are doing personal cares" and "If accidents are happening or anything sinister, you don't have enough staff or time to deal with [people] properly".

The provider had failed to ensure sufficient numbers of staff were deployed at the service. This place 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.

● Records relating to recruitment were not always robust.

● The files of 2 staff members did not contain Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. These were later found elsewhere in the service after it had been highlighted by the inspector.

● We also found 2 staff members files did not include all of the appropriate background checks.

We recommend the provider reviews systems and processes for safe recruitment.

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 comprehensive 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 people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff completed appropriate training necessary to enable them to carry out the duties they were employed to perform. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Relevant training and appropriate support was not in place for staff. We could not be assured suitably skilled staff were deployed.
● The training matrix showed poor compliance with a number of training modules the provider considered mandatory. For example, fluid and nutrition had 38.46% compliance, emergency first aid at work had 33.33% compliance and basic life support had 27.27% compliance. Concerns were identified with practice regarding food and fluids during inspection.
● There was no evidence of supervision taking place and limited evidence of staff appraisals. The provider confirmed they were unable to provide any evidence of staff supervision. 1 staff member told us supervision was, "Hit and miss".
● The provider was not following its own policy regarding supervision. For example, the staff support, development and appraisal policy noted the following, "All staff members will be offered and be expected to attend a 1:1 meeting at least four times each year". This was not in place.

The provider had failed to ensure staff received appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform. This was a continued breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to ensure an accurate, complete and contemporaneous records were consistently maintained. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of

regulation 17.

● Records associated with food and fluid monitoring were not accurately completed. For example, on 3 occasions the fluids for 1 person had not been totalled for the day. In addition, during inspection a staff member recorded an entry of fluids having been consumed by a person with no evidence they had consumed the drink.

The provider continued to fail to ensure accurate, complete and contemporaneous records were consistently maintained. This was a continued breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not always supported to drink enough fluids placing them at risk of harm.
● 1 person was assessed as being at risk of developing a urinary tract infection. The care plan documented they required "2 litres of fluid per day". However, their fluid charts contained the generic total of "1200 - 1400mls" for all people. For 9 days, they had not been offered the amount of fluids specified in their care plan. There was no further intervention regarding their lack of fluid intake.
● People were not always able to access drinks when they required, and fluids were not readily available. We found people had to wait a long time for drinks in the morning. For example, 1 person was repeatedly asking for a drink or some breakfast. Staff told the person, "Soon," however, they were still waiting 50 minutes later. In addition, 2 people told us their drinks jugs had not been replaced and 1 person's drink had been placed out of reach. Juice jugs for 2 people had a sticker on with the previous days date.

The provider had failed to ensure reasonable steps had been taken to mitigate risks to people. This placed people at increased risk of harm. This was a breach of regulation 12 (2) 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 them receiving a service. However, care records did not contain accurate and complete information regarding people's care and support needs.
● Management in the service had limited knowledge regarding people's care needs. There was a lack of guidance in care records for staff to follow in order to support people safely.
● Care records were not person centred. There was minimal information regarding people's preferences. People's life histories had not been incorporated into care planning and care plan reviews were inconsistent. Where reviews had taken place, they frequently failed to identify where people's needs had changed.

Adapting service, design, decoration to meet people's needs
● At the time of inspection, some people at the service were living with dementia. However, there were no dementia friendly features in the home to support these people and enhance their living experience.
● Some people's rooms were not personalised and the environment was in a state of disrepair. For example, there was a discarded broken chair in a corridor and a broken cabinet in the lounge on the dementia unit.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked in partnership with other agencies, for example, district nurses and GP's. However, advice from professionals was not always sought in a timely way and advice was not always followed.
● There was a request for 1 person to be discussed during a multi-disciplinary meeting in February 2022. There was no evidence in the care records of this taking place and no record of intervention. We therefore

could not be assured an appropriate medical review had been sought in a timely manner.
● The district nurse was involved regarding 1 person's pressure care. However, we found staff were not consistently following advice regarding their repositioning times.

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.

● The service was acting within the legal framework of the MCA. Where people lacked capacity to make decisions, best interest processes were followed.
● DoLS applications had been made where the service suspected people were being deprived of their liberty. These were reviewed and re-applied for within required time frames.

Inadequate

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 comprehensive inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were not always well treated and supported. They were not always supported to express their views and make decisions relating to their care. Care records contained limited evidence of people or relative involvement in making decisions about care and support.
- Several people appeared dishevelled, untidy and unclean. For example, 1 person had greasy hair with dandruff and very long, dirty fingernails. In addition, 1 person had messy hair and was dressed in underwear and a t-shirt, and 1 person was walking round with one slipper on and a sock with a hole in.
- Relatives told us they had observed people not having their personal care needs met. For example, not having their teeth brushed, fingernails cuts and not receiving appropriate support with their personal hygiene.

The provider had failed to provide appropriate care to meet people's needs. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not consistently maintained. Staff did not always speak to people in a respectful way.
- The environment did not always support the maintenance of people's privacy and dignity. For example, the lounge area did not have curtains up at the large window and was overlooked by residential housing. We found one person stood at this window in a state of undress. The provider took action to address this after the inspection.
- Staff did not always use respectful terminology when discussing people or their needs. For example, during lunch 1 staff member referred to people as an "assist". Also, 1 staff member told a person to "give up" on 8 occasions, during a 30 minute period, in response to them shouting and banging on the table, with no further dialogue or attempts at providing reassurance.

We recommend the provider seeks advice and guidance from a reputable source to ensure people's privacy, dignity and independence is respected and promoted.

Inadequate

Is the service responsive?

Our findings

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

At our focused inspection (published 03 November 2020) we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were not supported and cared for in a person centred way, reflective of their needs and preferences.
- A care plan for 1 person documented their preference was to have a shower. However, this was not possible as their hoisting equipment did not fit in the shower area. People living on the ground floor, who required a hoist were unable to have a shower and were limited to being bathed in bed only.
- Care plans lacked information for staff to understand people's specific needs and provide guidance regarding how to support them in a personalised way. For example, 3 people's care records contained conflicting and inaccurate information.
- Care and treatment was not planned or delivered collaboratively with people or relatives.
- Care records for 2 people did not evidence any involvement from people or relatives. In addition, relatives told us, "[I] have never had a formal care plan review for [name]" and "I have never seen the care plan".

The provider had failed to provide appropriate care in line with people's needs and preferences. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not supported to take part in activities and follow their interests. There were no activities available and there was a lack of meaningful engagement with people.
- During inspection people were sat in chairs for long periods of time without any stimulation or anyone engaging with them. Staff engaged with people mostly when completing a task, for example, assisting them to move.
- There was no evidence of links being made with community organisations to support people in following their interests.

The provider had failed to ensure people were provided with meaningful activity which met their needs and preferences. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives and friends were able to visit people.

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.

● Care records regarding people's communication needs were not detailed and did not provide sufficient guidance for staff regarding how to support people's communication.

Improving care quality in response to complaints or concerns

● There was limited evidence of complaints being consistently recorded or responded to and used to improve care quality.

● There were no complaints logged for January, February, and March 2023. However, it was not clear whether there had been any. There were 2 complaints documented for April 2023, one of which was highlighted via the inspection. A relative told us they had complained to the previous manager about their relative's care, but nobody had given them feedback.

End of life care and support

● At the time of inspection there were no people receiving end of life support.

● The provider had a policy in place to support end of life care.

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.

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

At our last inspection systems in place did not effectively monitor and improve quality and safety of the service. The provider had failed to keep up to date and accurate records. This was a breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had not taken action to address shortfalls identified at the previous inspection. At this inspection there were continued breaches of regulations relating to safe care and treatment, staffing and good governance. There was also a new breach identified in relation to person centred care.
● At the time of inspection there was no registered manager in post. The previous registered manager had left the service 12 days prior. The regional manager was providing support until a newly recruited manager started. However, following our inspection, the regional manager stepped down and there is no longer a recruited home manager due to start. There was a new deputy manager in post who did not know people or staff well. They were not familiar with staff names or some resident's needs and risks.
● Quality assurance systems and processes were not consistently being implemented. They were not effective in identifying shortfalls and driving improvements. Where shortfalls had been identified, no action had been taken. For example, the latest governance meeting minutes dated October 2022 identified issues with documentation, staff training and food and fluid charts. However, this continued to be an issue during inspection. In addition, a case management review dated 5 April 2023 noted people should be weighed weekly. However, this had still not been actioned at the time of inspection and 1 person had not been weighed since January 2023.
● Systems in place were not effective as they had failed to identify and address systematic and widespread failings identified during the inspection. For example, risk management, learning lessons, IPC, medicines, safeguarding, staffing and recruitment, supervision, the environment, and person-centred care.
● There was limited evidence of oversight regarding accidents, incidents and safeguarding. Lessons learned were not identified and used to make improvements.
● The provider did not always follow its own policy regarding medicines management, supervision, and governance. For example, the "quality and governance programme 2023" documented that governance meetings were to be held "quarterly" in "January, April, July and October". However, this was not in place.

● Care records were incomplete, inaccurate, and contained conflicting information. This meant staff lacked guidance to support people safely and meet their needs.

The provider failed to ensure systems in place effectively monitored and improved the quality and safety of the service. The provider failed to keep accurate, complete and contemporaneous records. This was a continued breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider failed to seek and act on feedback for the purposes of evaluating and improving the service. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There were no systems in place to obtain feedback to improve the service.
● There was limited evidence of engagement with people. There was 1 example of a small number of people being asked 5 questions in February 2023. However, no action plan had been implemented as a result of people's feedback and no evidence of follow up being completed. This meant opportunities to improve the quality of people's experience had been missed.
● There was no evidence of engagement with relatives. Three relatives told us they had not been asked for feedback regarding the service. One relative told us they had been asked for feedback, however, "Nothing came of it" and "I found out there was a newsletter, but I have never had one".
● Staff did not have consistent opportunities to provide feedback. Staff meetings and supervision sessions were not consistently held. Where staff raised concerns, no action had been taken. For example, staff meeting minutes documented staff raised the issue regarding the shower on the dementia unit not being accessible for people requiring hoist equipment. No action had been taken to address this.

The provider failed to seek and act on feedback for the purposes of evaluating and improving the service. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider did not promote a positive, open and person-centred culture.
● Care delivery was task based and meaningful engagement between staff and people was limited. There were no activities on offer for people to participate in and people did not receive person centred care.
● The environment was unhomely, unclean, and in a state of disrepair. The atmosphere was sombre. People were not always spoken to in a respectful, kind, and caring manner. Their privacy and dignity was not always maintained.
● People and relatives did not feel confident in raising their concerns and they were not confident their concerns would be addressed. One person didn't want management to know they had spoken with us, and another person had several concerns they asked the inspector to raise with the provider on their behalf. In addition, when asked if anything could improve at the service a relative told us, "If I do raise a concern, please take it on board".

● Staff told us they enjoyed their job. Feedback included, "It has its challenges, it's not the best at the moment, but I love my job" and "Caring for people is my passion".

Working in partnership with others
● The provider did not always effectively work in partnership with other agencies.
● The local authority had visited the service to complete a contract monitoring visit in February 2023. The provider had taken no action to address the concerns raised during the visit and the issues remained during our inspection.
● There was evidence of partnership working with other professionals, for example district nurses and the GP. However, we could not be assured that advice, support or treatment was incorporated effectively into people's care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a policy in place regarding the duty of candour. However, due to widespread issues regarding recording and reporting of incidents we could not be assured the policy had been consistently adhered to.