Nightingale Group Limited

Nightingale Group ltd. Trentham Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Nightingale Group ltd. Trentham Care Centre is a care home providing personal and nursing care to 111 people at the time of the inspection, some of whom were living with dementia. The service can support up to 155 people. People who used the service were both younger and older adults who had mental health needs such as dementia, and physical disabilities. Nightingale Group ltd, Trentham Care Centre accommodates people across five different units, each of which had their own purpose built facilities.

People's experience of using this service and what we found
People did not consistently receive their medicines safely or as prescribed.

People were not safe as the provider failed to identify risks or put effective measures in place to mitigate potential harm.

People were not protected from the risks of abuse or neglect as the provider failed to consistently follow reporting procedures when concerns were raised with them.

Although there were enough staff to support people the provider could not effectively demonstrate staff had the right skills and training to safely meet people's needs.

People were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible or in their best interests; the application of policies and systems in the service did not always support best practice.

The provider did not consistently learn from incidents, accidents, or near misses as their processes were inconsistent and did not robustly identify and promote good practice.

People were not always treated with kindness or compassion, nor was their dignity respected by those supporting them.

People did not have their privacy respected or promoted by staff.

People were not always offered choice, nor their preferences known or respected by those who supported them.

The provider's quality checks were ineffective in identifying or driving good care. Managers and staff were not clear about their roles, their understanding of quality performance, risks or regulatory requirements.

The provider had failed to make notifications to the CQC as required by law.

Although we were assured in other areas regarding the providers infection prevention and control practice, staff members incorrectly wore their face masks at multiple times throughout our inspection.

The last rated inspection rating was on display at the location and on the providers website.

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 29 December 2021). At that inspection there were breaches of regulation regarding safe care and governance processes. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on actions we told the provider to take at the last inspection. Additionally, we had received concerns about the care provided. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led.

We looked at infection prevention and control measures (IPC) 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 the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nightingale Group ltd. Trentham Care Centre 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 monitor the service and will take further action if needed.

We have identified breaches in relation to keeping people safe, safeguarding from abuse, providing dignified care, staffing, overall governance and notifying us about significant events.

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

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Nightingale Group ltd. Trentham Care Centre

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
Day one of this inspection was carried out by five inspectors, a medicines inspector, a specialist nurse and 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.

Day two was carried out by two inspectors and a medicines inspector.

Service and service type
Nightingale Group ltd. Trentham Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Nightingale Group ltd. Trentham Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered

with the Care Quality Commission to manage the service. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

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 all this information to plan our inspection.

During the inspection
We spoke with 12 people living at Nightingale Group ltd. Trentham Care Centre and two relatives. In addition, we spoke with 33 staff members including nurses, domestic support, nurse support, carers, care coordinators, human resource staff, staff trainer, registered manager, maintenance staff, external consultant and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with one visiting healthcare professional.

We spent time in the communal areas and we 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.

We looked at the care and support plans for 22 people and multiple medication records. In addition, we looked at several documents relating to the monitoring of the location including quality assurance audits, health and safety checks, incident and accident reports. We confirmed the recruitment checks of five staff members.

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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) 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.

● Staff were not consistently aware of the risks to people's health. One person told us, "I have type one diabetes and they (staff) don't quite know how to manage it. They don't handle it well and it's more like guesswork. They keep offering me cakes that I should not have." This put people at risk of harm from staff who were not aware of people's individual needs.
● People were not safe as the provider failed to consistently assess, monitor or mitigate risks to their safety. For example, following reports about a known risk to one person the provider had failed to identify what environmental measures they could take to reduce the potential for harm. This put people at the risk of harm from unassessed environmental hazards.
● Risks to people as a result of impaired skin integrity were not effectively managed by staff. For example, we saw people were identified as high risk of skin breakdown and therefor required frequent repositioning to maintain healthy skin. Records we saw showed many instances where this was not provided and there were lengthy gaps in repositioning. This put people at the risk of avoidable skin damage.
● Risks to people as a result of poor diet and nutrition were not effectively managed by the provider. One person said, "They [staff] should keep a monitor for me but they have lost the chart." Where people were at risk of dehydration of weight loss there were gaps in recording and monitoring. We could not be assured the provider was effectively identifying when people required additional healthcare intervention. This put people at risk of harm as a result of their changing needs not being effectively managed.
● We saw staff engaging in unsafe practice when supporting people. For example, we saw one person was being supported to move from one location to another in a wheelchair. The staff member failed to safely engage the footplates on the wheelchair causing the person's foot to drag on the floor. We intervened and supported the person to safely access the footplate minimising the potential for injury. This put people at the risk of mechanical injury from unsafe staff practices.
● The provider failed to ensure staff were aware of the risks associated with people's care were effectively communicated to staff supporting them. For example, we spoke with one agency staff member about the

person they were supporting on a one-to-one basis. The staff member did not know the person was living with epilepsy and didn't know what to do should the person experience a seizure as this had not been communicated with them. This put people at the risk of harm as staff were not aware of how to safely support them.

● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. However, throughout the inspection we saw some staff not wearing face masks correctly.

● We were not assured the provider was using personal protective equipment (PPE) effectively and safely. Staff told us they had received training in infection prevention and control however, we could not confirm this as the records provided by the management team were blank. Some staff used poor food hygiene practices when supporting people with their meals. For example, we saw staff members touching people's food with their bare hands. These issues placed people at the risk of communicable illnesses.

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 Mental Capacity Act [MCA]. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards [DoLS]

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

● However, people were not always supported in the least restrictive way possible. For example, we saw care and support plans which stated people should be encouraged to take medicines to maintain wellbeing. If they declined consent and did not have the mental capacity to make informed decisions about their medicines, there were systems in place to administer these medicines covertly. However, we saw staff members reverting to covert medicines in the first instance without encouraging the person to decide for themselves and therefore not following the guidance provided to protect people's rights.

Using medicines safely

● Medicines were not managed safely. The audit of the medicine administration records (MAR) showed some discrepancies between the quantity of medicines found and the administration records. These discrepancies showed the provider was unable to demonstrate people had received some of their medicines as prescribed. One person said, "I was not able to move my bowels for over a week. I needed Senna medication, but they couldn't get hold of it from the pharmacy and there was no communication about this from shift to shift."

● There were inconsistencies with the written plans for people who had been prescribed medicines on a when required basis. We found written information was not available for some when required medicines. Some of the written plans in place did not have sufficient information to inform the staff of when it would be appropriate to administer these medicines. We also found some written plans were in place for medicines that had not been prescribed on a when required basis. These inconsistencies meant people may not receive medicines when they needed them.

● We found where people needed to have their medicines administered directly into their stomach through a tube there was no robust written information in place to inform staff on how to prepare and administer these medicines safely. As a result, we observed the unsafe administration of medicines via a percutaneous endoscopic gastronomy (PEG) tube. The medicines were not administered in line with good practice to

prevent the risk of medicines interacting with each other before reaching their intended absorption site in the body, which would reduce their efficacy. We intervened to prevent any harm to the person in this instance. Poor administration techniques also increased the risk of the medicines causing blockages of the PEG tube.

● To maintain people's health and wellbeing some people were having their medicines administered by disguising them in either food or drink, this is known as covert administration. We reviewed the information available for these people and found not all of the necessary measures were in place to ensure these medicines were administered safely.

● A system was in place for recording where on the body analgesic skin patches were being applied. This was done because manufacturers of these patches set out how often a patch can be applied to one part of the body to reduce the risk of side effects. We looked at five people who had been prescribed these patches and found the patches were not being rotated around the body in accordance with the manufacturer's guidance. We found staff were not always recording where the patch had been applied. We also found one person had not had their patch changed for 14 days, when it should have been changed after seven days and two other people had their patches changed after nine days.

● Records did not provide assurance the medicines being stored in the refrigerator remained safe and effective to use. We found staff had measured the minimum temperature and were recording temperatures below two degrees Celsius. In order to ensure these medicines remained safe and effective they must be stored at between two and eight degrees Celsius. We were not assured of the competence of staff to administer medicines safely. We observed staff administering medicines and witnessed some poor practices.

Learning lessons when things go wrong

● The provider did not have effective systems in place to learn when things went wrong. After our last inspection, we issued a warning notice following concerns regarding the safe administration of medicines. We found improvements had not been made and people continued to receive unsafe support with their medicines.

● Although incidents and accidents were reported the management team did not have effective systems in place to follow up and review what was reported. For example, following a report one person had missed their medicines for several days there was no follow through by the management team to see what could be done differently to minimise the risk of it occurring again. Additionally, we also saw this person had missed other medicines which had not been identified as part of the initial report to the management team or by the managers reviewing the incident.

● The provider had systems in place to address any unsafe staff behaviour. This included retraining or disciplinary procedures if required. However, this was not effectively applied. One staff member told us, "I have raised concerns about staff interaction many times. But we keep getting the same (agency) staff back time and time again and we keep getting the same issues. No one seems to be doing anything."

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection site visit we passed our concerns to the local authority.

Systems and processes to safeguard people from the risk of abuse

● People were not safe from the risks of abuse and ill treatment. The providers systems and practices were not effectively followed to protect people. For example, we saw one incident where a concern of an abusive nature had been identified and reported by staff. The management team failed to follow recognised

procedures and had not reported this incident to the appropriate authorities.
● Following a review of the providers incident and accident recording we identified four other incidents which contained elements of abuse which should have been reported to the local authority as part of the safeguarding procedures. The provider failed to identify these incidents contained abusive elements and had failed to follow the procedures for reporting potential abuse.
● The provider could not provide assurances staff members had received training on how to recognise or respond to safeguarding concerns.
● Information was not readily available to people or visitors in a format which was accessible to them on how to report concerns.

Systems were not robust enough to safeguard people from abuse and improper treatment. This placed people at risk of harm. These issues constitute a breach of Regulation 13: Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following identification of these concerns we passed the details to the local authority.

Staffing and recruitment
● People were not consistently supported by suitably qualified or experienced staff. We confirmed with the registered manager on day one of the inspection there were 20 agency staff members supporting people. We asked to see the staff profiles to provide reassurance these staff members were appropriate to support people. The management team could only provide eight of these profiles. We were told by a member of the human resources team the person who usually coordinates this was not at work and therefore could not provide all of them. The provider could not make assurances they knew which staff were actually providing care or whether or not they had the necessary skills to safely support people.
● The registered manager told us their expectation was for all agency staff to complete an induction to the home. However, we saw quality checks which identified these were not being consistently completed. The inductions we did see made no reference or prompts to understand the people they were going to support. One staff member told us they had not been given any information about the person they were assigned to support including what they liked, disliked or any risks to be aware off.
● We saw one person becoming distressed. The staff available did not know how to intervene to effectively support this person. Another staff member, not in a caring role, intervened as they knew the person well. Staff deployed did not have the skills to safely support this person at this time.
● The provider did not have effective systems in place to record staff members training. We asked the registered manager and human resources manager for a copy of staff training records. Neither could provide this. The provider could not assure us the staff deployed had received training to safely support people.
● The nominated individual forwarded us several documents relating to training, but these did not contain effective information regarding the training provided or actual attendance. It did not identify course content or whether the staff members had actually completed this training.
● The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks and provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, they did not have effective systems in place to ensure staff supplied by an external agency were suitable for deployment at their location. For example, the provider failed to look at agency staff members profiles. We saw one registered nurse did not have a personal identification number (PIN) associated with their staff profile. The PIN is compulsory for working as a nurse in the UK. The provider failed to check staff profiles or to challenge where there were potential gaps in staff details before deploying them to work with people.

The provider failed to deploy enough suitably qualified, competent and experienced staff to enable them to effectively and safely meet people's needs. This placed people at risk of harm. These issues constitute a breach of Regulation 18(1) : Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were assured the provider was preventing visitors from catching and spreading infections.
- We were assured the provider was meeting shielding and social distancing rules.
- We were assured the provider was admitting people safely to the service.
- We were assured the provider was accessing testing for people using the service and staff.
- We were assured the provider was making sure infection outbreaks could be effectively prevented or managed.
- We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes

- The provider was supporting visits in line with the Government guidance.

- The registered manager told us they had measures in place to mitigate the risks associated with COVID-19 related staff pressures.

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 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.

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

● People did not have their privacy promoted or supported by staff. One person told us, "I have to keep asking for the urine bottle and the agency staff do not understand me. The urine bottle smells because it is not sterilised properly by the staff which means I have to try and use my own shampoo to clean it. This is very humiliating for me because it smells and I feel that any member of agency staff will then judge me for that."
● We saw people were treated in an undignified, disrespectful and degrading way. For example, we saw one person required assistance with their meal. The staff member did not communicate with them at all during the meal only to say "No," or "Don't do that," when the person tried to push the staff's hand away. There was no understanding the person may not have liked what was being fed to them or any attempt to make the experience pleasant for them. The person appeared to be distressed. The male staff member then proceeded to wipe down this female's chest area to remove food debris without seeking permission or understanding they maybe distressed by having a male approach them in such a way.
We intervened, and the provider removed this staff member.

● We saw other examples where people received undignified and disrespectful support from those supporting them. For example, we saw one person standing with their underwear around their lower legs whilst a staff member held their hands. This staff member did nothing to protect this person's dignity and it was another staff member who intervened to lift the persons underwear.
● We saw one staff member holding someone's food with their bare hands as they cut it before then going to support them to eat. Another staff member scooped dropped food from a table and put it back into the person's bowl before then feeding it to them. These are instances where staff members displayed a disregard for the dignity of the individual they were supporting not least effective food hygiene practice.
● People did not have their individual diversity respected or promoted by those supporting them. One person told us, "There are lots of agency staff and I can't seem to understand them, and they don't understand me." We saw staff members supporting people whilst holding conversation between themselves in a language unfamiliar to the person they were supporting. We asked a staff member if the people requiring support were familiar with this language and we were told no. As far as the staff member knew the people in the area only spoke and understood English. In addition to not respecting the person as an

individual with consideration to their protected characteristics this proved to be confusing and disorientating to those living with dementia. We physically saw people becoming anxious and looking around when those supporting them spoke between themselves in a language unfamiliar to them.

● Staff members did not demonstrate respect for people. For example, during one meal we saw an agency staff member come into the lounge area where people were being supported to eat. They did not engage with anyone, went to the television and turned on a music channel. They did not show any regard towards those eating a meal or whether they wanted the music on in the first instance. We spoke to this staff member about their understanding of dignity. They told us, "We always put on gloves." This demonstrated a complete lack of understanding of dignity and respect for those being supported. We asked why they had decided it was a good idea to turn on a music station. They told us, "Mine [the person they were supporting] has gone to sleep." This demonstrated a complete lack of respect for the person and others in the area and portrayed 'ownership' of an individual in a disrespectful way.

● We saw individual care and support plans which in places referred to the wrong name and changed reference between gender types. For example, one medicines care plan referred to the person, who was female, but the documentation referred to her as he. We checked with a staff member regarding this person's gender identification and they confirmed with us they identified as female. This lack of detail was disrespectful and lacked dignity for the person.

People's individual dignity was not respected by those supporting them or those directing care and support. These issues constitute a breach of Regulation 10: Dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we passed our concerns to the local authority as we perceived the interactions, we had witnessed to be abusive.

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

● People gave us differing views whether they were involved in decisions about their care. One person told us they now regularly have a shower and can have one whenever they want. However, some of the practices we saw did not promote the involvement in people's decisions. For example, people did not routinely get a choice regarding which gender supported them, what food they ate when supported with meals or even which television channel was put on.

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

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively to ensure the regulated activity is carried out safely. 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 provider was still in breach of regulation 17.

● At this inspection there was a registered manager in post. The management team were not clear about their roles and they did not have an effective quality monitoring system in place to identify improvements or drive good care. We were aware the provider had a continuous service improvement plan in place. We requested to have sight of this at the start of our inspection. The registered manager could not locate this and eventually provided a copy the following day. The registered manager confirmed to us they were not using this to identify improvements and had struggled to locate it.
● The quality systems they did have in place were not followed by the management team. For example, we saw one medicines quality check with the outcome identified as failed. The guidance stated this should be repeated weekly until it passed. We spoke with the registered manager who told us, "I know what you are going to say. We haven't repeated this for five weeks to see if it is any better." The management team failed to follow their own procedures for monitoring the safe use of medicines.
● We raised a potential safeguarding concern with the registered manager on 9 May 2022. When we returned on 18 May 2022 the registered manager confirmed they hadn't alerted the local authority as per their policy. We asked the nominated individual why this had happened, and they told us they didn't know about it. The management team did not have a day to day understanding of the culture of care provided within their location.
● The management team completed a managerial walk around check where questions were asked about the induction of agency staff members. Most of the checks we looked at confirmed the agency staff member had not received an induction to the location or the role they would be undertaking. We asked the registered manager how they assured themselves those in the building were suitable. They told us they couldn't be assured.

● The human resources manager told us they had a problem with the training systems, and no one could access information regarding staff training or competencies. The provider had failed to identify and employ an effective contingency to assure themselves staff were trained and effectively deployed.
● The provider failed to complete checks of people's individual care and support plans to ensure they were accurate and reflected their current needs. We saw gaps in recording people's weights, fluid and food intake. We saw people's records referred to the wrong gender and in places the wrong name. Where people had a DNACPR record or a ReSPECT document these were not consistently checked to ensure the information was current and accurate. For example, we saw documents which had differing addresses and had not been reviewed. DNACPR stands for do not attempt cardiopulmonary resuscitation. A ReSPECT document is completed following an advance care planning conversation between someone and a healthcare professional.
● The provider failed to complete checks to ensure staff had the correct information on which to be able to effectively support people. For example, we saw plans which referred to behaviours which challenged yet did not detail how the person was to be supported to help them at such a time.
● The provider failed to ensure staff deployed had sufficient understanding of the English language to effectively support people. One staff member told us, "Language is a barrier with some staff as this is not their first language. We have raised it several times and we are told management are introducing a test, but nothing has happened to date."
● The provider was issued with a warning notice following our last inspection with a date of the 10 January 2022 by which to be compliant. They had failed to take positive action to meet this requirement. We reviewed the last five inspections regarding this location completed since 2016. All inspections have found improvements were required in the well led key question. The provider has failed to drive improvements in how this location was managed for the last seven years. The providers quality monitoring processes failed to identify or correct the issues we found at this inspection.

The provider did not have effective governance, including assurance and auditing systems or processes in place. These issues constitute a continuing breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not appropriately submitted notifications to the CQC. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. For example, the provider made an alert to the local authority following an allegation of abuse and they had failed to inform us as required by law. We have identified other missed notifications which, at the time of reporting, were still being investigated.
We are looking at potential failures to notify and will report on our findings once completed.

● We saw the last rated inspection was displayed at the home in accordance with the law. The last rating was also displayed on the provider's website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff gave us differing views on how they were supported. Some told us they thought the management team were supportive and approachable whilst others told us they didn't feel listened to and their concerns went unaddressed. One staff member told us they had just been assaulted by the person they were supporting. They said no one has asked them how they were. They were just told to fill in the accident form. Another staff member told us, "If I were to score morale out of ten it would be a four or five. Its about just keeping people safe and not about keeping them happy here."

● The provider could not assure us staff understood the policies and procedures that informed their practice including the whistleblowing policy. Staff did not feel confident raising concerns with the management team as they had lost faith in receiving a positive response.
● People told us they found the unit managers to be approachable and responsive although they did not know who the other managers were. People found issues raised with the unit managers were addressed to their satisfaction in a timely way.

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 was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment. However, the provider did not have effective systems in place to identify or respond to concerns which had been raised with them. They did not follow procedures for responding to incidents of concern raised with them or to provide evidence-based outcomes on investigations.

Continuous learning and improving care
● We could not be assured the management team had kept themselves up to date with legislation and best practice used to drive improving care. This was because they had failed to initiate and maintain effective practices and were in breach of multiple regulations at this inspection.
● The management team kept themselves up to date with changes in guidance from the NHS and Public Health England in terms of how to manage during the pandemic.

Working in partnership with others
● The management team had established links with other health care professionals. For example, GP, and social work teams. Any advice or recommendations were recorded in people's individual care plans. However, this information was not consistently known by the staff supporting people.