Royal Bay Care Homes Ltd

Royal Bay Residential 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:

Royal Bay residential home is a care home registered to provide residential care for up to 42 people. There were 33 people living at the service at the time of the inspection. People who lived at the home included people who lived with complex needs including disabilities and long-term conditions such as dementia, sensory loss, Parkinson's disease, diabetes and Chronic Obstructive Pulmonary Disease [COPD]. COPD is an umbrella term used to describe progressive lung diseases including emphysema, chronic bronchitis, and non-reversible asthma. We were told that two people were receiving end of life care.

People's experience of using this service:

Some people did not always receive safe care or treatment at the home. People were at continued risk of serious harm and injuries.

Some people did not always receive access to healthcare services in a timely way which meant they were left with significant injuries, pain and serious deteriorating health conditions with avoidable delays to receiving appropriate intervention and treatment. Staff were not suitably skilled or knowledgeable and did not recognise serious deterioration in people's health. This placed people at significant risk of harm, injury and deterioration in their health conditions without timely urgent care or treatment from appropriate professionals. Serious incidents and concerns were not always recognised, investigated or reported under safeguarding guidelines by the management or the provider, so the relevant agencies were not aware and could not take action.

Lessons were not learnt from serious incidents and practices were not changed to mitigate risks of further harm to people. Following the last inspection, the provider sent us an action plan to tell us how they would ensure people were safeguarded from the risk of falls. At this inspection people continued not to be safeguarded from the risks of falls and serious injury. Staff did not follow moving and handling best practice techniques which placed people at risk of harm.

Medicines were not always managed safely which placed people at risk of harm. Staff were not always skilled or suitably trained to understand the effects of the medicines given to people. Staff did not use systems to help them identify when people may be in pain if they could not tell staff this, as some people were living with dementia.' We could not be assured that there were sufficient numbers of suitably skilled staff to give people their medicines when they needed it and when it was prescribed.

The risk posed by some people's medical conditions were not always managed effectively, such a diabetes. Some people were at significant risk of dehydration. One person was admitted to hospital due to signs of being unwell and on admittance was diagnosed as being severely dehydrated.

Where some people had been assessed as significantly underweight this was not managed safely to reduce further unexplained weight loss.

There was not always sufficient competent staff with the right skills and knowledge to support peoples complex needs safely and with dignity and respect.

Call bell records showed and people told us that not all calls for assistance had been responded to by staff. The manager confirmed that the some calls for a person had been 'reset' without staff attending to them at the time, this had left a person feeling 'frightened'.

There was a negative culture which meant that staff were afraid to challenge practices and a lack of managerial and provider oversight where opportunities to identify themes from incidents were missed to help prevent possible further injury.

Candour was not culturally evident throughout the staffing, management and provider levels. The manager told us, "I'm not going to lie and cover up anymore."

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the home did not support this practice.

There were systemic failings across the home that meant people did not always receive safe care or treatment. As a result, we asked the provider to take urgent action to make people safe. We made urgent safeguarding referrals to the local authority and to the police regarding the serious concerns we had about people's immediate safety.

Rating at last inspection:

At our last inspection on 27 February 2018 [Published 29 June 2018] we rated the service as 'Requires improvement.' At this focused inspection the service was rated as 'Inadequate.'

Why we inspected:

This focused inspection was undertaken due to information of risk and concern about serious injury and recurrent reports of people falling at the home that had not been reported to us. We had identified and been told by health and social care professionals of concerns about the management and leadership of the home.

Enforcement:

We have taken urgent action to safeguard people from the risk of harm. 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:

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?

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 well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Royal Bay Residential Home

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 12 March 2019.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of Safe and Well-led to at least good. The provider told us they would implement robust systems to safely monitor and respond to the risk of falls for people. At this inspection this had not happened. The provider also informed us they intended to ensure that medication errors did not occur. At this inspection this had not been addressed safely for people.

This focused inspection was prompted by information of concern regarding incidents of serious harm to people that had been raised to us by social services and health professionals. At least three of these incidents are subject to an investigation by CQC and as a result this inspection did not examine the specific circumstances of these incidents. The information shared with CQC about the incidents indicated potential concerns about the management of risk in relation to falls. This inspection examined those risks.

The information shared with CQC about incidents showed potential serious concerns about the management of risk of falls, scalding, hydration, unsafe moving and handling techniques. Concern was expressed about delays in reporting and seeking medical assistance for serious injuries to healthcare professionals. We looked at these concerns in detail during the inspection.

Inspection team:

The inspection was carried out by three Inspectors, and an Expert by Experience [ExE]. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The ExE had expertise in supporting older people living with dementia who used regulated services.

Service and service type:

Royal Bay Residential Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had appointed a new manager since our last inspection. They started their role as manager in July 2018. They were not registered with the Care Quality Commission. This means that the provider remained legally responsible for how the service is run and for the quality and safety of the care provided. The home has without a registered manager since December 2017.

Notice of inspection:

The inspection was unannounced.

What we did:

The provider had not been asked for a Provider Information Return [PIR] because we had undertaken the inspection at short notice due to concerns for people's safety.

During the inspection process we spoke with 11 people, three people's representatives and reviewed:
• Statutory Notifications we received from the provider
• Ten people's care records and wound records for all that had been documented. We reviewed a total of 31 injuries and incidents for people between 24 October 2018 and 9 March 2019
• Six people's medicines records
• Three staff members' recruitment records
• Staff training plan for all staff
• Records of accidents, incidents, complaints and compliments
• Audits and quality assurance reports
• We observed activities and the lunch time meal experience for people
• Observed the care of people using the service and spoke with one person's visiting relative
• We spoke with two members of care staff, two senior carers, the manager, the deputy manager, the administrator, the clinical director, the communications director
• We spoke with West Sussex County Council's [WSCC] social services social workers, team managers, senior managers and the police.
• We spoke with the community admission avoidance matron, the community admission avoidance dementia specialist matron and two paramedic practitioners.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at significant risk of avoidable harm. Some regulations were not met.

At our previous two inspections the 'Safe' key question had been rated as 'Requires Improvement.' In April 2017 the provider had not ensured care and treatment was provided in a safe way. Risks to people were not adequately assessed and appropriate action was not taken to mitigate those risks.

At our last inspection in February 2018 the provider had not ensured they had done all that was reasonably practicable to mitigate risk and manage medicines safely. Potential risks were not identified, appropriately assessed and planned for. At this inspection we found an ongoing consecutive breach of Regulation 12 [Safe care and treatment].

Since the last inspection serious injuries had been sustained and appropriate action had not always been taken to respond to, report or mitigate risk adequately. The provider had failed to provide care and treatment in a safe way for people. Actual and potential risks were not assessed, and the provider had not done all they could to mitigate any such risks to people. Some medicines continued not to be managed or given safely.

Assessing risk, safety monitoring and management:

• At our last inspection in February 2018 records of accidents and incidents were not accurately maintained, and staff did not routinely take appropriate action following accidents and incidents to ensure people's safety. We were told by the manager that there were no records detailing what had happened or follow up action to prevent a reoccurrence for many incident, accidents and near misses. And that there was no analysis which looked for any trends or patterns to help prevent reoccurrence. At this inspection we identified the same concerns. There was a lack of action taken by the staff to record, investigate or mitigate the risks for people following accidents and incidents.

•Staff did not always follow moving and handling best practice techniques, which placed people at risk of harm. We observed, and staff described how people had been moved unsafely. One staff member told us that they had seen unsafe practice, using an under-arm lift. This can cause pain and damage to people and can also be a cause of injury to staff. They said that the member of staff involved, "Hasn't had manual handling training." We reviewed staff training records which confirmed that their moving and handling training was "due." The manager confirmed this was accurate and that member of staff had not had training.

One staff member described to us that a person who had recently sustained an unwitnessed fracture also had unexplained, "bruising under both arms." The persons records did not record this observation by staff. Another person's daily notes in the 'Report Book' in February 2019, stated, "Big black bruise on side and

under armpit. Body mapped." The manager confirmed that no investigation had been carried out to establish how the bruising had occurred. We observed one person whom staff were trying to support to sit in a wheelchair which was positioned in front of them which did not support them to be moved safely. The brakes were not on the wheelchair and it started to move which placed the person at risk of a fall, staff had not noticed this until it was highlighted to them.

People did not always have the correct equipment to support safe moving and handling techniques. A member of staff told us they had concerns about the moving and handling equipment and said that the manager was, "Accepting people before we have equipment to look after them." They told us that people who needed them did not have their own "slings". This was confirmed by a moving and handling specialist who said that slings were not always used correctly by staff and had condemned some slings as they were not fit for safe use. They said, "Three slings had labels that were no longer readable and 2 slide sheets no longer where fit for use as they did not slide. A staff member told us they did not believe people were moved safely. They said, "Because I don't think we've got the equipment because they have to share."

The manager told us that 11 people were at risk of falling. They told us 10 of the 11 people had not been referred for professional advice on how to manage the risk safely. The provider failed to ensure systems or have oversight to safely manage these risks or to respond to them without delay. One person had been referred to the falls prevention team but only when significant injury had occurred from falling. Ten other people who were assessed as at risk of falling had no falls prevention action plans or assessments to reduce or prevent further risks from falling.

•During the inspection we identified 28 injuries and/or incidents where records showed that risks to people's health needs had not been adequately assessed or actions taken to mitigate risks to prevent further harm. These incidents and injuries had happened to 16 people between 24 October 2018 and 9 March 2019. The providers records did not demonstrate the actions taken to try and identify how these injuries had occurred or what medical support had been provided following significant injuries.

A person had recently had a suspected fractured rib, following a witnessed fall. There were no records or risk assessment following the fall to mitigate the risk of further falls. There were no changes made to their care planning to take into account their injury and of any specific care needs they may have in relation to this. There was no clear staff instruction of what observations they needed to make to identify any deterioration the person may experience as a direct result of their injuries. Following an unwitnessed fall, another person had sustained an injury to their leg their records did not show what actions had been considered to reduce further risk of falls. Eight days later the person had an unwitnessed fall and sustained a head injury that required hospital treatment.

•Staff did not always recognise when medical assistance was needed following incidents and falls. Before the inspection we received safeguarding concerns from social services which had been reported to them by an ambulance crew. They have been called to the home by staff in response to a person who had sustained a fracture. The ambulance crew said that staff were unsure when it had happened, but they said the person had fallen multiple times over the weekend. They thought they had fallen out of bed. The ambulance crew believed from the colour of the bruising the person had fallen over 24 hours previously and that no ambulance had been called in that time. The providers representative told us they were not aware of this concern raised. The ambulance crew and relative said that they had raised these concerns with the provider directly and through a safeguarding investigation undertaken by the local authority.

During a routine community healthcare professional visit to the home they found one person had significantly injured their arm. They told us that they were informed by staff that the injury had taken place

five days earlier, but staff were unable to tell them what had happened. The person had received no medical treatment or pain relief for their injury. Following treatment in hospital, the person was prescribed strong pain killers to manage their pain. This meant the person may have suffered with pain and discomfort before appropriate treatment was sought for them by the community healthcare professional.

There were no injury records for a person who had sustained an unwitnessed fracture. The records did not note whether staff had taken any immediate action to support them. One staff member told us the person had been dressed by night staff following their injury, without pain relief or urgent medical treatment. There were no records to confirm what action had been taken to reduce the pain for them. A healthcare professional told us that whilst visiting another person at the home a staff member had asked them to review the bruising to this person's arm. As no other immediate emergency treatment had been sought the healthcare professional ensured this was done without delay. The person was sent to hospital where a fracture was confirmed. There were no records of this incident to demonstrate how it happened or what medical attention was sought. A healthcare professional confirmed there were no records and that staff did not know what had happened. Staff confirmed that the electronic system to record incidents was not completed and they were not trained on how to use it effectively. A member of staff told us that staff will notice a bruise but will not check records or record it.

• Risks faced by some people's medical conditions were not always assessed and appropriate action taken to mitigate them to ensure that people received safe care.

•One person's complex needs meant that they were at increased risk of developing sepsis rapidly . Staff had failed to act to provide safe catheter care or to give them sufficient fluids. Sepsis is a serious condition that can potentially lead to organ failure, shock, and death.

During our inspection a healthcare professional told us about their concern for the person at risk of sepsis They said, "I am worried about [person name] doesn't want to get out of bed. They have gone downhill." The senior staff member present did not recognise this. The senior carer said, "He's jolly now, [feeding himself] as long as he's sat up." The healthcare professional continued by stating, "There is no strap to keep the catheter attached to their leg, the night bag is still attached. I know they get septic overnight and he won't be able to coordinate [or communicate their needs] and would need antibiotics." The senior carer responded when asked by the healthcare professional how often the person's catheter should be emptied. "It should be every 2 hours." The health professional asked when it had been emptied. The senior carer stated, "It says on here [hand held device] that it's 8 hours overdue." The senior carer confirmed that night staff had not checked the catheter overnight. This placed the person at high risk of developing a potentially life-threatening infection.

We reviewed the fluid chart for the person to check the amount of drink they had been offered and given throughout the day. There were omissions in the records and the person had not received the amount of fluid which had been set as their 'target' on a daily basis for the previous three days. We asked staff if the person had received the fluids they were assessed as needing. The staff member said, "It is really hard to get this amount into them." No action had been taken to seek advice from health professionals that their daily target of fluid had not been given or to identify other techniques to support the person to drink. This placed them at risk of developing infection and dehydration.

Some people's daily fluid intake were not always recorded consistently by staff and we could not therefore be assured that people received their fluids as needed. The manager told us of a safeguarding concern regarding a person who had been "readmitted" to hospital with, "Dehydration" 48 hours after they had been discharged back to the home. The manager acknowledged that no further systems had been put into place

to manage this person's or others hydration needs. This left people at risk of not receiving adequate fluids.

The person's relative visited them four days after they had been admitted to the home. They found them "confused" and said they had "deteriorated." The relative raised concerns with the home and a health professional visited the following day. The person's blood pressure was described as low and they were "severely dehydrated." The person had told their relative, "I don't feel safe here." The person required immediate treatment for dehydration. Staff had failed to identify or respond to this deterioration in the person's health needs and told instead relatives this was "normal."

• Some peoples were at risk of their diabetes not being managed effectively. A person who lived with diabetes required insulin to manage their condition. Staff did not always take appropriate action to safely manage their blood sugar levels. Within the daily 'Report Book' it had been recorded in January 2019 that, "Blood sugar 15.7 keep an eye on what they're eating." There was no guidance for staff on the persons safe blood sugar range and what to do if their blood sugar exceeded this range. There were no follow up evidence if their blood sugars had been managed safely for them after this high reading. The provider subsequently told us that a community nurse had informed them that they had responsibility for managing their diabetic condition. However, there was no reference to this in their care records that we were provided with. There was no guidance for staff to follow when monitoring changes to the person's condition because of their high blood sugars. We could not be assured that the person received safe diabetic care from staff. There was no guidance for staff on the persons safe blood sugar range, what to do if their blood sugar exceeded this range or when advice had been sought from the overseeing community nurse.

Records stated on the 17 February 2019 a person with diabetes had been, "Hallucinating. Not passed much fluid. Monitor all night." The manager confirmed that there were no assessments of risks or guidance for staff to follow regarding this person's diabetes. Records did not state how or what staff would need to monitor and what action they should take. We could not be assured that the person had received appropriate care or treatment in response to their long-term health condition. Training records showed that no staff had been trained in diabetes management. Therefore, we could not be assured that staff were competent to support people with diabetes.

Using medicines safely:

• At out last inspection in February 2018 safe procedures for giving people their medicines were not always followed which placed some people at risk of not receiving their medicines safely. At this inspection we continued to find that not all medicines were being managed safely. People were not always given pain relief medication when this was prescribed, in response to these concerns we asked the provider to send us an action plan. They told us they would ensure that medicines were given safely and the action they would take to avoid further medicines errors. The provider said that staff would follow their medicines policy.

•At this inspection, the actions stated by the provider had not improved practices and further medicine errors had happened. Some medicines are required to have additional storage and administrative measures to ensure their safe management and to meet legal requirements. There were two examples where the records for such medicines did not correspond to the stock being stored. This was regarded as a medicines error as the manager was not able to ascertain if this was a recording error or whether this medicine had not been given to the person in order to relieve symptoms. Stocks had not been checked since January 2019. The provider had a policy on the use of such medicines to support staff when such errors had happened and what actions they should take. This had not been followed and the provider did not have a system in place for the robust oversight of these medicines.

One person was placed at risk of overdose from such medicines. A healthcare professional made us aware of a 'near miss' incident regarding this person's medicine. They told us that a relative had been visiting them in the home and "witnessed staff gave them a dose of oramorph." Then, ten minutes later another member of staff came in to give a second dose of oramorph, but the relative had stopped them." We raised this concern to the manager who said that they did not know about the incident. The providers medicines policy states 'near miss' incidents should be reported to prevent this happening again.

During lunch time on the day of our inspection one person who lived with Parkinson's Disease had not yet been given their time sensitive medication at 6am that day. We notified the senior staff of the error. No action was taken to identify any impact for the person of a missed dosage, for example seeking medical advice. The staff member continued to give the next dose at 12:45pm which was later than the time prescribed. Time sensitive medicines must be given at the time they are prescribed to help ensure the stability of the person's condition. If it is not it can place the person at risk of the symptoms of their condition becoming worse.

Medication administration records [MARs] were not always completed in line with best practice guidance. For example, where the prescribed instructions need to be handwritten by care staff, the Royal Pharmaceutical Society guidance is that these instructions need to be signed by two staff to confirm the accuracy of the copied instructions. In the case of one other person who received medicines for Parkinson's their handwritten prescribed instructions were not signed by two staff members. After the inspection it was identified that the person had not being given their medicines for Parkinson's whilst at the home as had been prescribed by the prescriber.

There were no 'as required' [PRN] protocols for people to receive medicines on as 'as required' basis. These medicines may be required for the management of pain or constipation for example. Four people were prescribed paracetamol on as 'as required' basis. There were no individual protocols or guidance for staff to clearly indicate why people may need this medicine, who may not be able to ask for pain relieve due to their dementia or guidance for how frequently it should be given.

We observed that staff did not know what the medicines some people took were for. We asked a staff member who gave medicines to a person for Parkinson's Disease. They did not know what these medicines were for, the significance of the timing of such medicines and of any side effects that they should be aware of. On the day of our inspection the morning medication was administered later than usual because there was a misunderstanding about who was responsible for administering these medicines. Medicines were given later than prescribed and there was no consideration for delaying any next dosage to ensure sufficient time between dosages of some medicines. We found a lack of staff understanding of the provider medicines management policy which was not followed.

Preventing and controlling infection:

• People were not always protected from the risk of infection and adequate measures were not always used to identify or prevent risks of infection to people, staff or visitors to the service.

One person's care plan identified them as a carrier of Clostridium difficile (C.diff). There was no information or guidance for staff about how to manage the risks of a person who is a carrier. For example what symptoms to be aware of which may show signs of the infection becoming active. A healthcare professional stated they were not told of people who may carry infectious conditions when visiting, in order to take any necessary precautions to prevent them spreading infections to other services they visit.

• One person had a history of removing their own urinary catheter. We saw that the person attempted to remove their catheter and were told by staff that this happened on a weekly basis. There was no guidance for staff on how to support this person's catheter care. The lack of guidance for staff did not protect the person from the risk of infection or other risks associated with their catheter, such as blocking or bypassing. A senior staff member confirmed this was not in the person's risk assessment. They said that when the person does frequently remove their catheter, they are in pain and confused.

Learning lessons when things go wrong:

• Lessons had not been learned when things went wrong. The provider had consistently failed to adequately monitor, review, investigate or mitigate against the risks of unsafe care and treatment for people which placed people at risk of avoidable harm.

The provider had failed to investigate and implement mitigating actions to prevent the risks of scalding to people. Two months prior to the inspection, a person who was receiving care in bed had sustained a significant scald injury to 20% of their body. At the time the provider had not acted to investigate this injury. The providers representative told us they had started to investigate the day before the inspection. They confirmed that no mitigating action had been taken to prevent this risk to others. Some continued practices placed people at potential risk of accidental scalding as one person told us how the hot water system in the bathrooms was unreliable so instead 'staff bought up hot water from the kitchen'. There was no assessment or mitigation of the risks of this practice, including whether hot water being used was temperature regulated.

People did not always feel safe from harm and concerns about peoples safely were not always listened or acted upon. One person told us that they did not always feel safe as at least three people who had dementia frequently walked into their room uninvited. The provider and manager had not acted on complaints received from relatives and other health and social care professionals about people's safety. One relative raised significant concerns with the provider in relation to the safe care and treatment and subsequent significant injury following a fall at the home. Social services shared information with us that the person's relative had identified previous concerns to the manager regarding the person's safety and their concerns surrounding their increase in medication contributing to the risk of them falling. The manager had not taken action to consider the concerns / complaint to help identify the cause of increasing falls for this person being highlighted by a relative and the care records for this person. The manager confirmed that there was no record or action taken in response to the concerns raised by the relative.

We reviewed three complaints and the managers response. We observed that the manager at the time made a note, "There seems to be a theme of complaining" in relation to two verbal complaints (2 March 2018; 5 March 2018). The person's complaint on 5 March 2018 was that they, "Rang bell, agency staff member turned bell off, left in urine as a result." At this inspection the theme of call bells not being responded to remained an ongoing concern for people. The provider and manager had not recognised the value or importance of the complaints they received which were identifying concerns about people's safety.

The provider had failed to provide care and treatment in a safe way for people. The provider had failed to mitigate risks to people which had placed people at risk of significant harm and injury. The provider had failed to manage medicines for people safely. These concerns are a continued 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:

• People were not always safeguarded from the risk of abuse or improper treatment. The provider, manager and staff had failed to follow safeguarding procedures when serious risks to people's safety had happened. Not all staff had received up to date safeguarding training. Four out of 16 staff had not received safeguarding training. Before this inspection we had been informed by social services of three people who had serious injuries with no proactive action taken by the staff to seek immediate medical intervention for their injuries. This left people at risk of harm, infection and pain with a lack of pain relief given to relieve their symptoms.

Our observations showed staff lacked insight into what constituted abuse and a lack of understanding of abuse and neglect by omission of care. A number of safeguarding issues we identified during our inspection had not been recognised as safeguarding issues or reported by staff. Although staff told us they were aware of their responsibility to keep people safe, they failed to identify some of the practices within the home were abusive and breached people's rights to receive safe, respectful and dignified care.

At this inspection we observed a continued culture of poor practice amongst staff in relation to safeguarding. Staff had not raised concerns they witnessed under safeguarding guidance. They had not told social services about serious injuries and incidents for people. For example, of the 31 incidents of injury or health related incidents for people only one had been referred onto the relevant authorities for review. We discussed this with a member of staff who was distressed and acknowledged that the concerns for people's safety should have been reported under safeguarding. The management team had failed to develop a robust system to review which incidents or accidents resulting in injury to people were notifiable to safeguarding or to the CQC. The manager said that 'sometimes' they believed that staff intentionally failed to respond to concerns and risks for fear of safeguarding investigations.

The manager provided us with examples of staff intentionally not following safe practices that had a negative impact for people. They said, "Yesterday I went to [person's name] room. They'd been a bit sick, they had no drink. I rang the buzzer. Waited for carer and someone had turned the buzzer off. So, I pressed it again and it got silenced again. I don't know who cancelled it." We spoke to the providers representative who stated they were also aware of this incident. No action had been taken to investigate or address this. We asked for copies of the call bell log for this time period. We found the example the manager had described which confirmed what they had told us.

There was conflicting information about the call bell log. Both the manager and providers representative could not provide assurances that people were actually seen by staff before the call bell was reset. Therefore, we could not be assured if staff were resetting call bells at a call bell point in a person's room or from another location. Subsequent to the inspection the provider informed us 'remote cancelling' can only silence the noise and not cancel an alarm and if it is not answered within two minutes then the alarm will resume. There was no system to check why so may call bells were recorded as being 'reset' from another location without staff physically attending to the person's needs at the time the person made a call. This meant there was a risk that people may not consistently receive staff support when they needed it or wanted it. We saw that the call bell for another person had been tied around the call point, out of their reach. We spoke to a staff member. They said, "I could have died when I saw that today." They told us the person, "Could use it if she had it yes, most of the time she uses it to ask where she is." Staff knew the person could use the call bell and had tied it out of their reach which would prevent them from calling for assistance.

We reviewed the call bell records from 7PM 11 March 2019 to 7AM 12 March 2019. Twelve people called for staff assistance a total of 43 times during this period. Some people's 'call' showed that they were 'reset' without evidence to support if staff physically attended to their needs at the time they called for assistance. For one person, they called for staff assistance during that night and records did not consistently show that

staff had assisted them as required each time they called for help. People had reported that they had not been responded to as they needed, which had left one person feeling "frightened."

• Systems and process to monitor, analyse and mitigate risks to people following accidents and incidents were not robust and had failed to identify or flag serious concerns for people's safety. During our inspection we reported the safeguarding concerns that we found, and those that staff had reported to us. We asked that social services attended the inspection and further safeguarding concerns were identified which they reported they were investigating. Following this inspection, social services confirmed that they were investigating safeguarding concerns relating to 21 individual people who had lived at the home. Some of these 21 people had multiple concerns identified for them which included, but were not limited to, unexplained bruising, medication errors, skin damage and pressure sores, significant weight loss, failure of staff / management to appropriately identify or respond to deteriorating health conditions to minimise risks of potential or actual harm, unexplained fractures and other serious injuries for people.

The provider had repeatedly failed to safeguard people from abuse and improper treatment. Allegations of abuse were not investigated by the provider which placed people at risk of further harm and abuse. This is a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment:

• There were not enough staff to meet people's needs at night. Staff did not have sufficient time to respond to people's changing needs or to respond to emergencies or incidents. Staff absences were not always covered with suitably skilled or competent staff which left staff on duty under pressure and unable to respond to people's needs in a timely way. For example, on the nightshift 11 March 2019 staff were absent due to sickness. This left one permanent staff member on duty and two agency staff. Two people did not receive their time sensitive medication as prescribed. We were told by the manager that the permanent member of staff was not competent to administer medicines as had not yet received training. They said that it was practice that agency staff did not always give medicines to people. Following our inspection, a health care professional informed us of a further occasion when four people did not receive their medication as prescribed due to lack of suitable skilled staff. This meant that people were at risk of becoming unwell or being in pain due to not receiving their medicines as prescribed.

We asked the manager what process they used to assess the number of staff they needed to meet peoples assessed needs safely. They said, "we've been told what staff we can by the directors." A staff member told us, "I have said this to directors, I said we haven't got enough staff to ration of people. Another member of staff said, "I also think it's lack of staff. I don't think it's enough."

We received consistent feedback from people about inadequate staffing levels. Their comments included: 'Staff just do not have the time to pay the level of attention to each individual' "No way is there enough staff. They use a lot of agency staff" and "You can wait a long time for them to answer the bell. If I ring at night its variable." A staff member said of agency staff, "They're just chucked in at the deep end." A social worker told us that a person had, "Told me that in the night she needed the commode. She has a pressure mat but had been told not to get up without help. However, whilst she pressed and pressed her call bell, no one came. She said she had no alternative other than to "wet" the bed. During our inspection we spoke to the providers representative and expressed our concern that there were not enough suitable qualified, skilled staff on duty at night to meet people's needs safely. In response to the urgent action that we asked the provider to take they deployed an additional staff member at night.

We were told by staff and the manager that the staff member who was responsible for the laundry was on leave. There was no arrangement to cover their leave or systems put in place to ensure that people had sufficient clean clothes. Social care professionals shared the experiences of a person they were supporting. They spoke of finding the person in their bedroom in a vulnerable and undignified manner. There was a strong unpleasant odour in their bedding. The person was lying on top of their duvet, head at foot end, with just a top on wrapped in a fleece and no underwear. A staff member said: 'The laundry hasn't been done and there are no clothes." The manager and staff member were unable to provide us with an explanation of support or provide reassurances regarding if any other measures had been put in place to address this or for other people. Social services on-site team took over responsibility to ensure the person was supported to maintain their dignity and dressed in suitable clean clothing. During our inspection we shared the level of concerns we had with social services about people's safety and staffing levels and in response they placed two additional social services staff at the home overnight for the proceeding three nights to monitor and ensure people's safety.

The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Safe recruitment practices were not always followed. We spoke to the providers representative about what assurances they sought about the suitability and fitness appointment of the current manager to ensure they were of good character. They could not tell us what how they ensured suitable candidates were chosen for senior positions. They were unable to provide us with evidence of the safe recruitment practices of the manager. They could not tell us or demonstrate they had taken appropriate or timely action when concerns that had been raised by us and social services about a senior staff member conduct and practices. The provider had not ensured there were robust systems to respond to concerns about the fitness of staff employed or take appropriate interim measures to minimise any risk to people who used the service.

The provider had failed to ensure that recruitment procedures were robust or consistently followed and therefore could not be assured that all staff were of good character. This is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

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

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

• The provider was not working within the principles of the MCA. Restrictions on people's liberty had not always been authorised. People's human rights and protected characteristics such as those identified for people who lived with a disability were not protected. Consent to care and treatment and best interest's decisions had not been made in line with legislation and guidance.

Deprivation of Liberty Safeguards (DoLS) protect the rights of adults with a mental health condition who, live in care homes or hospitals, are kept under continuous supervision and control, are not free to leave the care home or hospital, lack capacity to consent to being accommodated for care and/or treatment. It is the responsibility of care homes to contact the local authority if they need to seek approval for a deprivation of liberty. We were told by the local authority DoLS team that they had not received four out of the seven DoLS applications that the manager said had been submitted for people who had moved into the home since our last inspection. We asked a senior staff member about any conditions people may have under DoLS and they did not know.

Staff did not ensure people's mental capacity to make decisions was always assessed when needed. People who lived with dementia and may lack the mental capacity to consent to their care and treatment did not always have mental capacity assessments completed for the specific decisions that required consent. One person's care plan said they did not have capacity to make decisions. It did not specify requirements under the principles of this Act in that, an assessment of capacity must be decision specific. There was no capacity assessment for any specific decision.

We spoke to a senior member of staff who told us that information regarding mental capacity assessments

was not detailed within records for people. We asked them to show us on the hand-held device to access people's records. They were unable to use this easily and stated they had not had training to use the equipment to access information about people's needs. We saw the MCA section of another person's records, but they were blank. The staff member confirmed this was accurate.

A person told us how they felt that they were subject to restrictions that they had not consented to, they said: "Have the bed rails put up at night, they do not want these up at night as they do not want to use urine bottle while laying down and like to get up to use the toilet but told they are not allowed and needs to stay in bed." The person had been assessed as being able to make their own decisions.

• People's choices at the end of their lives may not always been upheld and respected. We could not be assured that people received appropriate responsive care at the end of their lives. One person died unexpectedly who was new to the home. Staff were uncertain of their DNACPR status. Ambulance records show that staff started CPR [Cardio Pulmonary Resuscitation] but then stopped this as they did not know if the person had a DNACPR in place. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. The confusion resulted in significant delays to the staff contacting the emergency services to assist them. Records did not clearly set out action to be taken in an emergency for this person and whether they may have wished to be resuscitated.

The provider had failed to obtain consent lawfully for people who lived at the service. This is a breach of Regulation 11 [Need for consent] 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 individual needs were not fully assessed to ensure that staff were able to meet their needs safely before they moved into the home. At our last inspection in February 2018 care was not routinely personalised to the individual, and we saw examples of people's preferences not being met and people not being supported to bath when they had chosen to. People did not always receive care in line with their assessed needs and that there was limited evidence that people's needs had been met or responded to in relation to identified nutritional risks for example.

After the last inspection, we asked the provider to send us an action plan to describe how they would address the shortfalls. The provider told us that, "All baths will be logged on 'Nourish [an electronic record keeping system] and will state the client's preferences, if a bath is refused the care plan will state a full body wash is to be given and the bath to be rescheduled to the afternoon or next day." At this inspection we did not see evidence that staff clearly recorded when care had been refused for bathing or what alternatives were offered for personal care. We were told at this inspection by the moving and handling specialist that the bath seats had not been safety checked and were not safe for use. The provider stated in their action plan that the, "In house [administrator/care manager] will oversee care plans and ultimately [providers representative]." This action had been addressed at the time of this inspection. The providers representative had not audited the care plans during their monthly monitoring audits to the home.

• At this inspection we found that the risks identified at our last inspection had not been addressed and peoples assessed needs continued not be delivered in line with good practice. We reviewed two pre-admission assessments for people who had moved into the home since our last inspection. Care and support for these two people was not based on an assessment of their individual needs. One of the assessments had been completed over the telephone by the manager. The assessment did not provide any

information to inform staff how to care for the person's needs. The person had specific complex needs. The staff had not had relevant training to support the person with their specific health needs. A health professional raised concerns about this person's deteriorating health since moving into the home and the risks that this placed on the person and others. A health professional believed there to be risks to the person and potentially to others too regarding their lifestyle choices. There were no risk assessments around these potential risks to the person or others. This meant that staff did not have the guidance needed to safely and consistency meet this person's specific health care needs.

For another person there was an incomplete pre-admission assessment of their needs surrounding behaviours that had challenged. It was reported in the 'Report book' that the person had been "Aggressive" towards two other people. There was no guidance in the persons care plan or risk assessment on triggers, de- escalation techniques to support these behaviours. The manager confirmed staff were not trained to manage these behaviours. The manager said, "We've got a few people 'sundowning'." 'Sundowning' is a symptom of forms of dementia. It's also known as "late-day confusion." Their confusion and agitation may get worse in the late afternoon and evening. On the day of our inspection one of the members of staff supporting this person had not had dementia training. A health professional told us that staff were not managing the person's behaviours well. They told us that the person, "Has significant behavioural issues and becomes very distressed. Hitting out disturbed and aggravated."

•People's ongoing needs were not routinely assessed to enable good consistent safe care. A relative expressed their concern that their relative had not been listened to or treated with dignity. The relative explained that their relative had to share a zimmer frame, and if the frame as in use their relative had to use a stick instead but felt as their relative was at risk of falling they really needed to use a frame. They said that, "Their bathroom in their bedroom does not work and they have to share a commode or their relative uses a urine bottle. The commode was full, and the person could not use until emptied and had been waiting since lunch." They stated that, "Since they have not been using the bathroom that they are strip washed in their bedroom, which they do not like. They stated they would like to be washed in the bathroom." They also said that, "They cannot get to their phone in time due to it being between the beds and them not being able to mobilise quickly enough when it rings." They said, "Staff won't move the phone." There was no assessment of the mobility needs of this person to ensure that their needs could be met in a safe and consistently way.

Before our last inspection we received concerns about people's mental health needs not being met safely by the staff and provider. Following the last inspection, we asked the provider what action they would take to ensure people received the care and support they needed. They sent us an action plan which included all staff receiving challenging behaviour training. At the time of this inspection staff told us and records showed this had been provide. Since our last inspection a person had displayed behaviours that may challenge due to their mental health. Five of 22 staff had not completed training to support people who lived with dementia and no staff had completed training to understand how to support people with behaviours that may challenge themselves or others.

•One person lived with visual impairment and their individual communication needs were not assessed, investigated or responded to. For example, the person had no alternative means to call for staff assistance when required, other than a call bell which did not work when their falls sensor mat was plugged into the system. The manager had not assessed this communication need for the person or provided them with a reasonable alternative. A Social care professional feedback that this practice had affected them because they were left for long periods of time with staff not responding to their call for help and no suitable alternative means to call for help.

People's communication needs were not assessed, and reasonable adjustments were not made to support

people. Staff were still not aware of the Accessible Information Standards [AIS] and no policy, procedures or training around this had been implemented following our recommendation at the last inspection.

•Peoples emotional needs were not assessed for example when a relative had died. We saw one person who appeared to be low in mood. We spoke to a staff member. They told us that their relative had passed away six months ago and they were still grieving for their loss. They had lived at the home together. We asked a senior staff member if the person had been supported by them or referred for bereavement support. They confirmed that this had not been considered.

The provider had failed to ensure that people received appropriate person-centred care that met their individual assessed needs or preferences. This was a continued breach of Regulation 9 [Person-centred care] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support, induction, training, skills and experience:

• Staff were not adequately trained, and many did not have the skills, knowledge and competence that is required to provide effective safe care or support to meet people's needs or to provide a good quality of life.

• Two members of staff told us that they had not received moving and handling training to support people from the floor after a fall. One member of staff said that the training was not effective. They said, "It is crap." A moving and handling specialist told us that staff had received a training session lasting one hour for moving and handling. At the time of this inspection the provider had not ensured that the manager had undergone moving and handling training to only ensure their safe practices but to enable their effective monitoring of good manual handling practices at the home. The National Back Exchange standards state that moving and handling training must be practical and for a minimum of three hours.

A Moving and handling specialist attended the home during our inspection to assess if people were moved safely. The specialist shared their concerns about the unsafe moving and handling practices they saw and consequently raised safeguarding concerns in response regarding the safety of three people. This included people continuing to be being hoisted when indicating they were in pain and a person being moved without the appropriate equipment.

• Technology did not always support the delivery of effective care and support for people as staff were not adequately trained or skilled to use the electronic record and care planning system. This meant that staff did not know how to use this to update records for people. A social worker and health professional told us that people did not always receive their required amount of fluids to drink each day. We asked the manager where staff would record fluids for people. They said, "Fluid intake should be in nourish and there's a way you can add daily targets." We asked if that happened for people. They said, "No" and confirmed that this was, "because nobody knows how to do it."

The provider told us that the electronic care records does not require WiFi to be effective as all new information would be downloaded when it was within range. However, we observed a senior staff member who could not access records for people on their hand-held device. They said, "It doesn't work in half the building because the Wi-Fi doesn't work. We don't know where to record things. There are different places to record the same things." They said, "No it doesn't tell you anything".

A senior staff member said that they had not received training on the use of electronic care records. We saw paper records for monitoring fluids for people had been put in place, but these were not completed consistently, and people did not achieve their target amount to drink each day. Staff did not consistently

know what action to take to support people safely and there was little management monitoring or oversight of this. One member of staff told us they had, "Done some shadowing before doing medicines" and that a senior member of staff had "watched" them do this. They had also completed "an online course as a refresher."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:

• Staff did not always demonstrate the necessary competence and skills to effectively share information and communication with other agencies to help support joined up safe care.

Information was not always shared with other services and information was often not communicated adequately by staff at the home. On the 8 March 2019 a health professional told us that a person had been admitted from the home to hospital with sepsis. They said that the, "Home identified that the person wasn't quite right. They had spoken to the GP surgery, they said observations were normal. They deteriorated later that day and the GP told them to phone 999." Staff had been trained by the health professional to inform the GP of specific signs and symptoms of health conditions for people that require an emergency response. This is known as 'SBAR' training. This technique was not used in this emergency. The manager could not answer why staff did not use this technique to ensure there was no delay to the person receiving care or urgent treatment.

The person was discharged from hospital back to the home. A staff member told us, "They now have acute kidney injury." A senior staff member told us that they felt they did not have adequate discharge information from the hospital to know how to meet the person's needs. This was not followed up by any senior staff. Staff had failed to take responsibility to ensure that care and support was coordinated between services which left the person at significant risk of not receiving safe care or treatment to meet their change in needs.

The provider had failed to ensure that staff were adequately trained, competent or skilled which placed people at risk of harm. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• The staff and management did not always ensure that people had enough to drink.

The manager told us that people's 'MUST' scores were not safely monitored, and that action was not taken when people's MUST score indicated they were at risk of malnutrition. MUST is a Malnutrition Universal Screening Tool used in care settings to assess and monitor people's weight loss closely. The manager told us, "Last month 15 people had a score of 1 or 2, 1 had score of 3". Those with a score of 2 or 3 are at 'Medium risk' and 'High Risk' of malnutrition. Part of the assessment criteria for people assesses as with 'High Risk' MUST scores have experience weight loss. A health professional told us that one person assessed as high risk had a significant unexplained weight loss of 1.5KG over a period of one month. No referrals to a dietician or GP were made. MUST audits were completed monthly with 'no action' recorded consistently this meant that unexplained weight loss was not being identified or acted upon.

Adapting service, design, decoration to meet people's needs:

• The premises and facilities were not designed with people's needs at the centre of their creation and did not meet people's needs or support them to maintain their independence. The dining area was located in

the conservatory which was very cold during our inspection. We spoke to a senior member of staff about this. They told us, "We used to have heaters. We've raised it, it's ongoing."

•. A specialist moving and handling advisor confirmed that a bath in use had not been LOLER tested. LOLER stands for 'Lifting Operations and Lifting Equipment Regulations 1998.' The purpose of the regulations aims to reduce the risk of injury from lifting equipment used with people. The provide confirmed that four months prior to the inspection a new bath with hoist has been installed.

The moving and handling advisor told us that lifting equipment for people was not always safe. They condemned the use of slings in the home and said, "Voyager hoist in bathroom was condemned on 20 September 2018 and needs to be disposed of and order of a replacement hoist." They found the, "Arjo Calypso bath lift/chair needs LOLER testing." Records showed people had received baths from 15 January 2019 to 1 March 2019 in the service's 'Records Book.' People were bathed using equipment which had not been correctly maintained which placed them at potential risk of harm.

The provider had failed to ensure people had access to safe, suitable bathing equipment and that these items of equipment were maintained safely for use. This is a breach of Regulation 15 [Premises] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At this inspection the home had significantly deteriorated since our last inspection in February 2018. Where the provider had failed to develop robust systems to identify that best practice in relation to medicines was not being followed, care plans and risk assessments were not accurate, and people's dignity was not always respected. Audit processes were not robust and had not prevented incidents taking place.

At the previous inspection in April 2017 there had been a breach of Regulations because the provider had failed to send us notifications of deaths. At this inspection the provider had again not fulfilled their legal responsibility to notify us of certain events and incidents at the home. We had not received notifications of alleged abuse including serious harm that the provider had a duty to inform us of. We had not been notified of at least ten serious injuries to people. The provider had failed to inform and notify us when they were required to do so in law. This was a breach of Regulation 18 [Notification of other incidents] of the CQC (Registration) Regulations 2009.

At this inspection we found ongoing and multiple breaches of Regulations.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care: Working in partnership with others:

• There had not been a registered manager since December 2017. We had raised concerns with the manager and the provider in December 2018 and in February 2019 regarding concerns about the managers abilities to undertake safe moving and handling procedures. At this inspection the provider had not taken action to investigate these concerns and the manager remained untrained in safe moving and handling practices. Therefore, we did not have assurances that they were competent to identify staff competences around safe moving and handling practices.

There was a negative, systemic culture among the staff, the management and the provider. Candour was not culturally evident throughout the staffing, management and provider levels. The manager told us, "I'm not going to lie and cover up anymore. I think the falls [are of concern]. Social services want it recorded and it never is."

Staff told us that leadership and management was very poor, and that fairness, transparency and openness was not encouraged or promoted. One staff member said, "Most of my problem is with the manager. She doesn't communicate." There was an evident culture of blame amongst some of the staff and a lack of trust or faith in the management and provider to take appropriate action to safeguard people from harm or

abuse. The manager confirmed that there was 'absolutely' a culture of bullying. We asked if they had reported these concerns to the providers representative which they said they had not. One member of staff said about the manager, "We all know the minute she's gone the atmosphere changes. We can all start smiling and laughing. I don't trust her."
The provider subsequently informed us that key senior staff were no longer working at the service.

Throughout this inspection, staff told us of their concerns which they had not reported outside of the organisation. Staff when talking to us were tearful and distressed about the incidents of harm that had happened at the home. One staff member had written a statement which was provided to social services about their concerns of safety and lack of appropriate management action when a person was hospitalised due to an injury. They told us that when an incident had happened, they felt the manager dealt with things after the event rather than preventing further harm to people. We asked if they had spoken to the manager or provider about their concerns. They said, "No, I can't talk to her."

We spoke with a senior staff member when describing the manager told us, "I feel since she's been here the home has gone down. There have been so many safeguarding's that she doesn't follow through." They confirmed that no investigations had been raised following recent falls to identify the cause and help further prevention. They said, "No incident form was completed at the time, safeguarding is never discussed. It was swept under the carpet." A further staff member told us, "The manager, she doesn't care about the residents, doesn't care about the staff" and "None of us feel confident to go to her." They said they had discussed their concerns about the levels of staffing being insufficient at the home. They told us that this concern had not been acted upon by the manager or directors.

• We reviewed the quality systems and processes, these were not robust, transparent or followed up issues to prevent known risk of harm to people. The providers representative told us they were a "qualified nurse" and that they completed "monthly inspections" at the home. We asked the manager to provide us with copies of the most recent "Directors monthly inspections [DMI] audits and reviewed the records of those monthly audits for the following dates; 22 January 2019, 26 February 2019 and we reviewed the "Homes yearly performance review" dated 29 October 2018. These audits had failed to identify or follow up any serious incidents or injuries or death. Within the February 2019 audit there was a section to review the 'monthly audits completed.' This had been left blank. The providers representative told us that they were not always aware of the serious injuries to people.

There was inconsistent evidence of action being taken to provide follow up care to people following a wound and for serious injuries such as fractures. There were no wound assessment charts completed. The providers representative said they were not aware of the incidents and appeared surprised by the seriousness of some of the injuries for people. The provider had failed to use their auditing systems effectively to identify injuries to people which meant they had not acted to report, monitor or mitigate risk to people as a result.

• We spoke with the providers representative about a scalding incident of a person. We asked them what action they had taken to investigate this serious injury. They told us that they were not made aware of the incident by the manager until two weeks after it had happened. This is despite police involvement and their contact with the manager to request records to investigate the incident. We asked what investigations they had completed to ensure the safety of others from scalding. They told us, "I investigated it yesterday11 March 2019]." They could not explain the significant delay in initiating an investigation or what immediate actions they or the manager had put in place to keep other people safe from the risk of scalding.

When we fed back to two of the providers representatives we showed them the evidence of the lack of

through investigation into establishing the potential cause of a scalding incident. They told us they were not aware of our findings and had not discovered these as part of their own 'investigation.' Their response was to apportion blame rather than to identify how best to ensure the ongoing safety of people through a more thorough investigation by the provider.

• The auditing quality systems, policies and processes were ineffective and did not assess, monitor and improve the quality and safety of the home. The provider had failed to identify or take appropriate action in relation to the significant concerns found during this inspection when safety concerns were known by the leadership team or staff. This is in relation to medication management, falls, equipment, injury, complaints and action had not been taken which placed people at serious risk of potential and actual harm. There were failings of the management and provider to ensure they and staff had acted in accordance with their organisational policies and procedures.

On the day of inspection, we asked the provider to urgently assess and review the serious concerns we discussed with them and provide us with details and assurances of what action they were going to take to ensure people were safe. We reiterated the seriousness of the concerns and need for immediate action the next day in writing. We did not receive the assurances that the provider was able to keep people safe from immediate risk of harm or injury.

We have taken urgent enforcement action. 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.

The provider had repeatedly failed to ensure safe systems were established to monitor and improve the quality and safety for people. This was a continued and ongoing breach of Regulation 17 [Good governance] 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:

• The provider did not monitor the day to day attitudes, values or behaviours of the staff or management team. The providers website stated, "We believe a home should be; Where each person is an individual, where there are no unnecessary rules and regulations; Where dignity, peace and comfort take priority; Where companionship, interest and activity flourishes; And where people are supported to lead the fullest possible lives." We did not observe that these organisational 'values' were being followed.

Staff were not at ease to report concerns under whistleblowing and did not feel supported or protected to do so. When discussing issues relating to medication at night and safeguarding for people, one member of staff who had worked at the home for many years said to us, "I'm pleased I can say it now" when describing their worries for people's welfare at the home. They had not felt able to tell the manager or provider about their concerns before. We observed the manager tell them "You can tell them [CQC], I have told them everything." This demonstrated the lack of prior openness and communication among the staff and manager regarding the safeguarding of people at the home.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

• The manager and provider did not understand and had not followed the Duty of Candour Regulation when people had experienced harm. The intention of this regulation is to ensure that providers are open and

transparent with people who use services and other 'relevant' people who may act on people's behalf if they lack the mental capacity to make decisions about their own care and treatment. Under this Regulation the provider must promote a culture that encourages candour and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. The manager told us that they were aware of the duty of candour process, but when asked to confirm the actions taken in the event of notifiable safety incidents, such as providing an account, advising relevant people, recording a written record or making an apology to people and / or their relatives. They said, that they didn't do this.

The provider did not act to take immediate or appropriate action following serious notifiable safety incidents for people. No actions had been taken to fully investigate or mitigate future risks to people or to others of avoidable harm. We reviewed information within our information systems which showed that two relatives had stated that they moved their relative from the home following concerns they had about the inadequate care. In response to the relative's complaints the provider had not responded to these concerns. Social services told us that the provider had failed to complete a safeguarding investigation that they had asked them to undertake in September 2018 following a safeguarding allegation. The provider did not always act in an open and transparent way.

The provider had repeatedly failed to act in accordance with this Regulation. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed repeatedly to notify the Commission, without delay, of serious injuries, safeguarding and incidents investigated by the police for people who lived at the home. This is a breach of Regulation 18 [Notification of other incidents] Care Quality Commission (Registration) Regulations 2009 (1) (2) (a) (b) (e) (f)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received appropriate person-centred care that met their individual needs or preferences. This was a repeated and ongoing breach of Regulation 9 [Person-centred care] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (1) (a) (b) (c)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to obtain consent lawfully for people who lived at the service. This is a breach of Regulation 11 [Need for consent] of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014 (1) (2) (3)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to provide care and treatment in a safe way for people. The provider had failed to mitigate risks to people which had placed people at risk of significant harm and injury. The provider had failed to manage medicines for people safely. These concerns are a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (1) (2) (a) (b) (c) (d) (e) (f) (g) (h) (i)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had repeatedly failed to safeguard people from abuse and improper treatment. Allegations of abuse were not immediately investigated by the provider which placed people at risk of further harm and abuse. This is a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act (Regulated Activities) Regulations 2014 (1) (2) (3) (4) (a) (b) (c) (d) (5) (6) (b) (d) (7) (b)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure people had access to safe, suitable bathing equipment and that these items of equipment were maintained safely for use. This is a breach of Regulation 15 [Premises] of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 (1) (c) (d) (e)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that there were robust systems and processes to ensure that people were safe from the risks of poor quality and safety. These concerns were an ongoing breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that fit and proper persons were employed. This is a breach of Regulation 19 [Fit and proper persons employed] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (1) (a) (b) (c) (2) (a) (3) (a)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to act openly with candour and had not openly investigated or taken appropriate actions to safeguarding people from harm or abuse. This is a breach of Regulation 20 [Duty of Candour] or the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (1) (2) (a) (b) (3) (a) (b) (c) (d) (e) (4) (a) (b) (c) (d) (7) (a) (b) (9) (a) (b)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were adequately trained, competent or skilled which placed people at risk of harm. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (1) (2) (a)

The enforcement action we took:

Urgent action to remove the location from the providers registration under Section 31 of the Health and Social Care Act 2008