KR Care Homes Limited

Bankfield

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bankfield is a residential care home providing accommodation and nursing care for to up to 47 people over the age of 65 and/or living with dementia. At the time of our inspection there were 18 people using the service.

People's experience of using this service and what we found
People were not always supported safely. Risks were not always identified, assessed, and monitored. Safeguarding processes were not always followed. Accidents and incidents were not always recorded. Recruitment processes were not robust. Agency workers did not have robust checks and inductions recorded. Medicines were not safely managed.

Consent was not legally obtained for care and treatment. Staff did not receive training to safely use the medicines system at Bankfield. Staff were not receiving regular supervision and appraisal. Assessments had not considered people's cultural needs. One person was left with a drink in front of them for three hours without any prompting to drink it. People had been moved into rooms with less facilities than they previously had and without consultation.

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 and in their best interests; the policies and systems in the service did not support this practice.

Staff were kind and caring but lacked time to spend with people. There had been multiple staff changes and regular use of agency staff which meant people lacked familiarity. People told us they did not always get a bath as the lift had been broken and the bath was on the first floor. Care records confirmed, people were not accessing the bath.

Care plans lacked detailed information and were not created or reviewed with people and their relatives. No complaints had been formally received by the provider but relatives told us, they had tried to contact the directors but were not responded to. Activities were available and people spoke positively about the activities coordinator. However, we were told, the activities coordinator was often used to fill care shifts.

The provider lacked oversight of the improvements needed to be made in the home. Audits completed had not highlighted the concerning information we found at this inspection in relation to medicines safety, safeguarding, care planning and risk assessing and the recruitment and retention of staff. The manager was not always open and transparent with us and there had been no consultation with people and staff about increases in care fees. The provider had failed to improve over the previous four inspections.

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 inadequate (published 14 December 2022). At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bankfield on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to person- centred care, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, staffing, fit and proper persons employed and fees at this inspection.

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 overall rating for this service is 'Inadequate' and the service remains 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Bankfield

Detailed findings

Background to this inspection

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

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors on both days of the location visit. An Expert by Experience attended the home on the first day of inspection and undertook telephone calls to relatives at a later date. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

At the time of our inspection there was not a registered manager in post. A new manager had been in post for six months and had submitted an application to register with CQC. The application was currently being

assessed and the manager was undergoing their fit person check.

Notice of inspection
This inspection was unannounced. Inspection activity started on 6 March 2023 and ended on 15 March 2023. We visited the home on 6 and 7 March 2023.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection, we spoke with the manager, a senior care worker and 11 people who were living at the home. We spoke with 11 relatives by telephone and 2 staff members. We also contacted 7 further staff members by telephone and left messages, but we did not receive any response.

We reviewed 7 care plans and associated risk assessments. We reviewed multiple medication records and information relating to the recruitment, training and supervision of staff. We looked at records for audit and oversight as well as safeguarding and accidents and incidents records.

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.

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 inadequate. At this inspection the rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- Procedures to share alleged abusive practices were not always followed.
- Two allegations of abuse had not been reported to the Care Quality Commission with one allegation not being reported to the local authority safeguarding team. The manager told us, they believed a senior staff member had reported the allegations.

Systems and processes to safeguard people from abuse were not always followed. This was a breach of regulation 13 (1) (3) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received training to underpin their knowledge of safeguarding vulnerable adults. Staff felt confident they could report any concerns they had to the manager.

Using medicines safely
At our last inspection, the provider failed to ensure medicines were safely managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the service remained in breach of regulation 12.

- Medicines were not safely managed. One person was given medicine that was over a week beyond its expiry date and another person was given an incorrect dose of their blood thinning medicine.
- Medicine records were not always completed accurately. The records did not show all medicines including waste medicines in the home were accounted for. The information about the colour and size of tablets did not always match the tablets supplied by the pharmacy, which meant staff could not accurately identify the tablets they were administering or omitting.
- When required medicines such as paracetamol or some creams did not have guidance to advise staff how they should be administered or applied.
- Information was missing to help staff give covert medicines safely. There was no information from the pharmacy about what food and drink each medicine could be mixed with.
- Medicines requiring refrigeration were not stored safely. The fridge temperatures showed insulin had been stored outside the recommended temperature.

We found no evidence people were harmed, however, the unsafe management of medicines placed people at increased risk of harm. This was a continued breach of regulation 12 (1)(2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection, the provider did not assess whether the applicant was of good character and make every effort to gather all available information to confirm the person is of good character. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, the provider did not effectively deploy staff to meet people's needs. The provider did not have an induction programme which prepared agency staff for their role. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the service remained in breach of regulations 19 and 18.

● Application forms for new staff members contained gaps and full employment histories were not always obtained.
● Dates of previous employments for applicants differed on application forms and references and the provider had not pursued this with the applicant.

The provider did not assure themselves recruitment checks were complete and satisfactory. This was a continued breach of regulation 19 (1) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Agency workers were used for shortfalls in staffing at the home. Of the 14 workers used for the four weeks prior to the inspection, 6 workers had no profile which meant the provider had not assured themselves of the workers training, experience and recruitment checks.
● In addition, of those 14 workers, 9 workers had not been inducted to the home and were not always aware of people's care and risk needs. A permanent staff member told us, "It's quite hard with agency (staff). They say they don't know how to use things. We have to show them how to use the electronic care planning system."
● One person told us, "There is a buzzer in room and they [Staff] come as quickly as they can but sometimes feels like a while but they do come to see you. They could do with a couple of more staff during the day."

The provider did not have an induction programme which prepared all agency workers for their role. This was a continued breach of regulation 18 (1)(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff employed by the provider had a disclosure and barring service (DBS) in place prior to commencing employment. A Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last inspection, the provider did not ensure risks to people were robustly captured as part of care planning and risk assessing processes. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the service remained in breach of regulation 12.

● Risks to people were not always identified and recorded with strategies in place to reduce risks.
● One person had a wound to their leg following an incident at the home. The district nurses were treating

the wound but there had been no updates to the skin integrity care plan or risk assessment to support effective wound management. There was no record of the incident which caused the wound.
● The same person was regularly using moving and handling equipment for mobilisation. No assessment had been completed to ensure the equipment was suitable and being used safely.
● A person at risk of choking had differing information in their care records about food consistency. The choking risk assessment recorded the person should have a level 6 diet which is soft, and bite sized and the nutritional care plan recorded level 7 which is easy to chew.

We found no evidence people were harmed, however, risks to people were not clearly identified or correctly recorded. This put people at risk of harm. This was a continued breach of regulation 12 (1)(2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other accidents and incidents were recorded, and a monthly audit was being completed to collate the information. It was not clear how this reduced further occurrences to keep people safe.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was following the most up to date guidance for visiting in care homes.

Inadequate

Is the service effective?

Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance
At out last inspection, the provider did not ensure consent was gained for care and treatment from the relevant person and the provider did not recognise consent could be withdrawn at any time and did not respect a person's decision to withdraw consent. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the provider remained in breach of regulation 11.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Care and treatment was not provided with the consent of the relevant person. The manager was signing to consent to people's care and treatment without the legal authority to do so. This had been raised at previous inspections.
- There was no evidence, families and representatives who had the legal authority to act in a person's best interests were always consulted about arrangements for care and support.

Care and treatment of service users was not being provided with the consent of the relevant person. This was a breach of Regulation 11 (1) (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had their capacity assessed and referrals to deprive those who lacked capacity to make decisions were made.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law
At our last inspection, the provider did not ensure assessments of people's care and treatment included all their health, personal, emotional, social, cultural, spiritual and religious needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, not enough improvement had been made and the provider remained in breach of regulation 9.

● The provider did not always assess people's needs and choices effectively and ensure the care provided reflected people's personal preferences.
● People's cultural and religious beliefs were not always encouraged once there was a deterioration in their health and cognition. Assessments had not highlighted the importance of ensuring these beliefs were central to person-centred care.
● People and their relatives were not actively involved in assessments of their needs.

The provider did not do everything reasonably practicable to make sure that people who used the service received person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they may be. This was a breach of regulation 9 (1)(2)(3) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff received an induction on commencement of employment; however, this was mainly completed in one day.
● Staff were not receiving any reviews of their probationary period and many staff had not received any supervision or appraisal.
● All staff had undertaken training in subjects related to their job role. No competency assessments had been completed to ensure staff were able to safety move and handle people or use food thickening agents.
● Staff received medicines training via e-learning but had not received any medication training specific to using the medication administration system at Bankfield. Medication competency checks of staff were incomplete.

Staff did not receive appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18 (2) (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
● People were supported to eat and drink; however, we monitored one person who had a cold cup of tea in front of them for almost three hours and staff had not encouraged the person to drink the fluid.
● Care records lacked details on people's preferences for food and drink. On the first day of inspection, one person's care record, recorded they did not eat a particular meat product. By the second day of inspection, this information had been removed without consultation with the person or their representatives.
● People told us, "I like the food, I get a choice." and "[Chef] is very good, we have a food choice of two things, and he always asked if we are enjoying the food at mealtimes."

Adapting service, design, decoration to meet people's needs
● The home was accessible for people with varying abilities and needs. Many parts of the home had been redecorated since the last inspection.

● Some bedrooms had private bathrooms; however, people had been moved to the ground floor without consultation which meant they no longer had access to their own ensuite facilities. A relative we spoke with told us their relation was unhappy about moving rooms.

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

● People received health and social care support from a range of professionals including GP's, district nursing and social work teams.

● A weekly review of people was completed by the GP surgery and any concerning information relating to health and well-being could be addressed promptly.

● People told us they could see a GP when they needed to.

● Relatives and representatives were informed when their relation became unwell or was reviewed by a health and social care professional.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

Ensuring people are well treated and supported, respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

At the last inspection, the provider did not do everything reasonably practical to make sure people who used the service received person-centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 At this inspection not enough improvement had been made and the provider remained in breach of regulation 9.

● The provider did not recognise the importance of ensuring staff have the skills and time to give people compassionate support when they need it. Staff did not have the time to sit and talk with people for a meaningful length of time. The provider did not always ensure schedules were organised, so people received support from familiar staff.
● There had been multiple changes in the staff team over the last four inspections and a new staff team was in place at this inspection. Agency workers were not always familiar with the people living at Bankfield.
● No consultation had been undertaken with people and their families following people being moved to the ground floor of the home. For some people, their new room was smaller and did not have the facilities they previously had. A relative told us, "My recent concern has been that [Name] has been moved to another room on the ground floor and [Name] is not very happy in that room. We have been told the lift is broken."
● People told us they could not always have a bath when they wished as the bath was on the first floor and due to the lift being broken. People were being supported with showers although some care plans recorded a shower only occurred once a week.
● One person was shouting on occasion throughout the inspection. Staff did not always respond to the distress and care records did not confirm strategies to reduce the persons agitation.
● Staff were very busy and did not have the time to sit with people and get to know them. One staff member told us there was no time to read people's care records.
● Our observations on the day of inspection showed staff were kind and respectful to people but were very busy and task orientated.

The provider did not do everything reasonably practical to make sure people who used the service received person-centred care. This was a breach of Regulation 9 (1)(2)(3) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People felt the current staff team were kind and caring. Comments included, "The old staff have gone now. The new staff are very good." and "The staff are fantastic to me."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

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

At the last inspection, the provider did not maintain an accurate, complete and contemporaneous records in respect of people living at the home, including a record of care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the provider was still in breach of regulation 17.

- Care plans were being reviewed by the manager, however there was no evidence of people and their representatives being involved in the reviews, so we were not assured the plans were accurate and reflected people's current needs.
- There was a lack of information to support people with skin integrity and distressed behaviour. Records of incidents were recorded in retrospect.
- Care plans to support the administration of covert medicines lacked detail and input from the pharmacy about the correct procedure to administer the medicines.
- Care records were not reviewed with people and their representatives to ensure they were accurate and reflective of people's needs.
- Staff told us they did not always familiarise themselves with people's care records due to time restraints.

The provider did not maintain an accurate, complete and contemporaneous record in respect of people living at the home, including a record of care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. This was a breach of regulation 17 (1)(2) (Good governance} of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Improving care quality in response to complaints or concerns

- No complaints had been formally received by the provider since the last inspection. However, relatives told us they made a number of attempts to contact the provider to raise concerns about a fee increase and in which they had not received any response. One relative told us, "I have tried to ring the director and social services have tried to get hold of them, but they have not rung either of us back."
- A policy was in place for the management of complaints.
- People felt they could complain if they needed to.

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

● People were not always supported to maintain relationships and avoid social isolation.
● A programme of activities was available, and people said they sometimes attended an activity; however, we were told the activities coordinator was often used to cover care shifts and care staff did not have the time to spend with people.
● People told us, "I enjoy playing bingo" and "[Activity coordinator] is brilliant, [activities coordinator] does bingo, quiz's, [activities coordinator] does my nails and last summer, we had a summer fair. If anyone needs to go the hospital, it's [Activity coordinator] who goes with them."

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

● Some signage was used across the home to direct people to their rooms or bathrooms.
● Pictorial menus were used to support people's understanding of the food available.

End of life care and support
● People were able to remain at the home should they be at the end of their life. Health and social care services were available to support end of life care.
● Some people had their end of life wishes recorded.

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 inadequate. At this inspection the rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection, the provider did not operate effective systems and processes to make sure they assessed, monitored and improved the service. The provider did not ensure effective communication systems were in place to notify external partners or relatives any information about the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, not enough improvement had been made and the provider remains in breach of regulation 17.

- The provider did not promote a person-centred culture. The provider was not inclusive, nor did they work positively to achieve good outcomes for people. The provider had failed to improve following the last four inspections.
- The provider lacked oversight of how the home was operating. They were not aware agency staff were not receiving an induction. The manager lacked understanding of the concerns found with the safe management of medicines and was not aware of safeguarding concerns not being reported through the appropriate channels.
- Permanent staff were working additional hours to cover short falls in staffing. Staff told us they were tired with some staff regularly working 60 hours or more per week. There were no effective plans in place to recruit and retain staff effectively.
- The provider had not engaged with staff who had resigned from working at the home to understand why there was a high turnover of staff.
- Managers and staff were not clear about their roles. They did not fully understand and embed quality performance, risk and regulatory requirements. They did not ensure the principles of good quality assurance.
- There were audits in place for medicines, health and safety, recruitment records and care planning. However, they had not highlighted any of the findings from this inspection.
- Only 4 medication audits had been completed since the last inspection and we continued to find concerns with the safe management of medicines which the providers audit process had not identified.
- The manager lacked openness and transparency. They were not honest when we raised concerns about medication and staff competency. The manager had permitted a staff member to administer medicines without the appropriate training and full competency check and then destroyed any records before we

could review them.
● Governance systems were ineffective as they were not capturing where care records lacked information or incorrect information.

The provider did not operate effective systems to monitor the service. The provider did not assess risks to people's health, safety and welfare or introduce measures to reduce or remove risks. This was a breach of regulation 17 (1)(2) (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; 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 did not fully engage with people and their representatives.
● Four relatives told us the provider had significantly increased the fees towards the cost for care without any consultation. One relative told us, "We were told by the manager a week ago, if you can't afford it, move [Relative] somewhere else." Another relative said, "I got a phone call from the home about a top up fee and that I had agreed to it. They said they would send a letter which I never received. I am worried sick"
● We found there had been no meaningful engagement or explanation given to people or their representatives. Relatives told us, the manager had been making telephone calls to request additional unagreed top ups to care, however the manager denied this.
● A flat rate charge had been introduced at a cost to people and their relatives, should they need support to attend appointments. No consultation or explanation had been given as to why the fee had been implemented.
● Relatives told us they had not been asked for feedback on the home and care provided. However, a relatives and friends survey had been completed in October 2022. There was no evidence the survey was completed solely by relatives and friends and no action had been taken where results were unsatisfactory.
● We found the manager to be defensive and lacked regard for the seriousness of the concerns raised at this inspection.

The provider had not given people information about the terms and conditions of their care, treatment and support, including expected costs and the requirement to pay for their care, treatment and support. The provider had not notified people of any changes to their terms and conditions or given sufficient time to consider whether they wish to continue with the service. This was a breach of regulation 19 (1)(2) (Fees) of the Care Quality Commission (Registration) Regulations 2019.

Working in partnership with others
● The provider had been supported by the local authority to improve following previous inspections of the home. It was evident improvements were not being embedded promptly to improve the service to an overall rating of good.