Esteem Care Ltd

Brandon House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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
Brandon House is a nursing home situated in the Meanwood area of Leeds and provides accommodation for up to 42 older people. The home provides single room accommodation with most rooms having en-suite facilities. The building provides wheelchair access throughout, with private grounds and parking facilities.

People's experience of using this service and what we found
People did not always receive a service that provided them with safe, effective and high-quality care. Risk management was not always effective. Some infection control practices were ineffective and potentially placed people at risk of harm. The management of people's medicines was not fully safe. Areas of the home looked tired and did not fully provide a dementia friendly environment.

Care plans were not always consistent, and some agency staff were not fully aware of people's needs. Governance arrangements were not robust. Audits undertaken had not always identified where improvements were needed so appropriate action could be taken. For example, in relation to the environmental and hygiene standards. People's records were not kept securely.

Staffing numbers were insufficient to ensure people received safe and timely support. Even though staff were caring in their approach, staff were task focused in their interactions with people. People's dignity was not always respected. Activities were limited and did not meet the needs of people who used the service. People's nutritional, hydrational and healthcare needs were not always met.

Staff understood how to identify and report any safeguarding concerns. Recruitment procedures were followed. Staff had received an induction, had completed mandatory training and supervision was conducted. However, appraisals had not been completed prior to these being started in June 2019.

People said they were happy with the service provided. People and relatives had the opportunity to provide feedback on the service received and there was a system to respond to complaints.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People's end of life care needs were met.

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

Rating at last inspection:
The last rating for this service was Good (published 19 March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement: We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 namely safe care and treatment, dignity, person-centre care, staffing and good governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
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**

Brandon House

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 Care Act 2014.

Inspection team
On the first day of our inspection, the inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector carried out the second day of the inspection.

Service and service type
Brandon House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We requested feedback from stakeholders. These included the local authority safeguarding and commissioning team and Healthwatch England. Healthwatch England is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with the registered manager, two nurses, five staff members and four ancillary staff. We also spoke with two visiting healthcare professionals.

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

We reviewed documents and records that related to the management of the service, including a range of policies, procedures and guidance used by staff in their role, records of safeguarding and complaints, audits and quality assurance reports. We reviewed five staff member's files and records associated with the management and administration of people's medicines. We looked at four people's care plans in detail, a further three care plans for specific information.

After the inspection
Additional evidence was sent to us and this information was used as part of our inspection. We looked at training data and further quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- There were not enough staff to ensure people received safe and timely support.
- We saw people requested assistance from staff but did not always receive it. For example, the registered manager told us because some people wandered, one person's bedroom had a gate put across their door. This person had to wait for 10 minutes for a staff member to be available to help them. On the second day of the inspection the gate had been removed. From our observations it was clear the staffing levels were low and meant staff could not support people appropriately.
- People had to wait for their breakfast because staff were busy supporting people with personal care. One staff member always had to supervise communal areas which meant they were unavailable to people who constantly required support.
- People who required supportive observations from one staff member did not always receive this level of support.
- We received mixed views from people and relatives regarding staffing levels. A person said, "There is enough staff during the day but not at night time. One time, I wanted to go to the toilet, but I was kept waiting two hours. Staff said I should use pads then I would not have to wait. I think that is wrong I do not need a pad I just need help sooner." A relative said, "There is enough staff, I can always find someone if I need to."
- People and relatives told us call bells were not answered in a timely manner. A person said, "When I press the button at night time it can take about half an hour before someone comes. During the day, not so long." A relative told us, "[Name of person] has a call bell but it takes them from between 10 and 20 minutes. I think that is unacceptable. I often have to go looking for staff they do not check on people enough." Both the registered manager and provider were going to review the staffing numbers.

The provider had not taken appropriate steps to ensure staffing levels and the deployment of staff were sufficient to always meet people's needs. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had been recruited safely.

Preventing and controlling infection

- The premises were not clean which put people at risk of infections.
- Areas of the home required a better system of monitoring infection control standards to avoid them being missed. For example, comfy chairs and bathrooms were dirty and there were areas of the home with unpleasant odours.

● The communal bath and shower rooms were cluttered and used as storage. For example, one bathroom had a wheelchair, a hoist and, two chair scales.
● Items of furniture were damaged and could not be properly cleaned. This included tray tables and 'crash' mats at the side of people's beds.
● There were insufficient staff deployed to ensure the home was clean and odour free.
● People told us the home was clean, however, we received mixed views from relatives. A person said, "It is cleaned every day, I know it has been done as often the floor is wet. I have not noticed any smells." A relative said, "They only have one cleaner, it's a disgrace there should be a team of cleaners not one to keep on top of it." Another relative said, "You do not get any smells here it is clean." The registered manager and provider were going to review the process for maintaining hygiene standards in the home.

We found no evidence that people had been harmed, however, infection control systems were not effective. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff used protective equipment such as gloves and aprons and had received training in infection control.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Accidents and incidents were monitored by the registered manager, but records did not include information of any lessons learnt.
● Care plans were not always updated following accidents and incidents.
● Assessment of risks to people were completed but appropriate action was not taken to ensure the persons safety. For example, one person was a high risk of falls, but they were not supervised by staff. Movement monitoring equipment was in place but this only alerted staff to the person's movements. The person also had problems with their mouth and was on a fork mashable diet, however, we observed them eating toast for breakfast. This meant people were not always safe as risks had not been well-managed.
● Some records showed advice was not followed. For example, one person had received advice from a healthcare professional regarding the use of thickener in their drinks. However, this was not recorded on the person's food and fluid charts.
● Some people did not have access to a call bell due to these being out of reach. Therefore, they would not be able to summon help if required.
● Whilst there was no evidence to suggest there was any impact on people, air mattress settings were not recorded in people's care plans. Staff did not have appropriate knowledge of what people's mattress should be set at. The registered manager told us they had recently reviewed people's mattress settings but was unaware of one person who was on an airflow mattress.
● Guidance was not always available for staff to support people who had nutrition and hydration needs.
● People's weights were not always managed in line with their care plan.

People's risks were not always well managed. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Service records, the environment and fire equipment were safe, routinely checked and well maintained. Key building certificates were found to be up-to-date.
● Staff had received training in fire safety. Each person had an up to date personal emergency evacuation plan that would be used in the event of an emergency.
● Some lessons were learnt when things go wrong. For example, following a recent complaint, the Sunday lunchtime meal option was reviewed and changed.

Using medicines safely

● Medicines were not managed safely. This included the storage, administration and recording of administration.

● Medication administration records (MARs) were not always signed to demonstrate topical cream medicines had been administered.

● Topical medications were not stored appropriately.

● Audits of medicines were completed on a weekly and a monthly basis and had not identified the issues we found. For example, an audit completed on 17 June 2019 had not identified topical cream charts were not completed by staff.

● Although, an audit on the 27 June 2019 had identified some people's creams had not been recorded, on day one of the inspection we noted the application of people's creams was still not being recorded and we could not be sure these had been administered as prescribed.

● MARs were observed being signed by an unqualified member of staff. The registered manager addressed this immediately.

● Nursing staff did not always ensure that keys to locked cabinets in people's rooms where medicines were stored were safe.

Medicine management was not always safe. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they received their medicines on time. A person said, "I always get it, morning, afternoon and evening. They ask me if I need pain relief and they give it when I need it."

● Staff had received medicines training, or their competency had been assessed.

Systems and processes to safeguard people from the risk of abuse

● Some staff were not always knowledgeable about how to protect people from avoidable harm.

● A staff member did not check they had closed one of the units exit doors properly and a person followed them out of the unit. Another staff member saw this and supported the person back into the unit.

● People and relatives said they felt safe in the home and with staff. A person said, "There are key codes on the doors and I have bed sides on my bed to keep me safe."

● The provider had safeguarding procedures in place and reported incidents appropriately.

● Staff said they had received appropriate safeguarding training.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's meal time experience was not always positive. Where people required support with their meal, we observed this was not always done in an inclusive way and there was no encouragement for people to eat their meal. For example, some staff were either standing over the person without interaction, not explaining what they were eating, or they were watching the TV. This was a missed opportunity to engage with people and make mealtime an enjoyable experience.
- There was a pictorial menu for people to choose their meal, however, this had not been changed since 9 July 2019.
- People had access to food and drink throughout the day. Although, one relative said, "[Name of person] does not eat any more, just fluids, but they do not give him enough to drink."
- People told us they were happy with the food. One person said, "It is always nice. Today I had ham and egg salad, there is always a choice. They do offer something else if I don't like what is on the menu."
- The chef was clear about people's dietary needs and how to meet these.

Supporting people to live healthier lives, access healthcare services and support

- The registered manager told us some people did not have access to a dentist due to a change in local contracts. They said they were looking for a dental provider but had not yet been successful except for one person.
- Care plans contained 'hospital passports'. Hospital passports are communication tools to inform other health services and professionals of people's health needs. We saw one person's hospital passport was dated 10 October 2016. The registered manager was not sure if this had been reviewed but said the content had not changed.
- Where people required access to other healthcare services, this was organised, and staff followed guidance provided. A person said, "You can see a doctor if you want one and I have my feet done. I speak with staff if I do not feel well."
- Information was recorded in people's care plans about healthcare professionals they had seen. A healthcare professional told us, "Staff generally follow guidance and advice."

Staff support: induction, training, skills and experience

- Mostly, people received care and support from skilled and knowledgeable staff.
- People and relatives said staff had the skills and knowledge to look after them. A person said, "They [staff] seem to know what they are doing, they know how I like to be handled when they are washing me." A relative said, "They help and support [name of person], I cannot fault them."

● Staff completed an induction programme prior to starting work. Staff new to care completed the Care Certificate. This is an agreed set of standards that sets out the knowledge, skills and behaviours expected of job roles in health and social care.
● Staff were given opportunity to attend supervisions to review their individual work and development needs. Although, not all staff had received an annual appraisal since our last inspection.
● People were supported by staff who received ongoing training. This covered key areas of care and support and training records were kept up-to-date.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they began using the service to ensure the service could meet their needs.
● The registered manager said they used legislation and guidance to improve the care and support people received.
● The registered manager shared best practice and information with another one of the provider's homes.

Staff working with other agencies to provide consistent, effective, timely care; Adapting service, design, decoration to meet people's needs
● Staff attended handover meetings at the start of each shift where relevant information was shared; this helped to ensure people received continuity of care.
● The environment required development to ensure this supported people living with dementia. The registered manager and managing director confirmed the current environment of the service had not considered best practice guidance for people living with dementia.
● There was signage displayed in the home, but this was not always easy to see. For example, some people's door names were not at eye level.
● Some people's bedrooms were nicely decorated with photographs and pictures which reflected their personal preferences. Other people's rooms were sparse and did not reflect their personality.
● The communal bath and shower rooms had limited space due to equipment being stored in these areas.
● Access to an outdoor garden area was provided with a seating area. However, this was not fully secure There are plans in place to address this.

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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Mental capacity assessments had been carried out when required. Where people were unable to give their consent, decisions were made in their best interests. One person said, "Staff are always kind and treat me well. They respect my choices and listen to me."

● Where people were deprived of their liberty, the registered manager worked with the local authority to seek authorisation for this to ensure this was lawful. Although, for one person who we saw had a gate across their bedroom door, an authorisation had not been applied for. On day two of the inspection, the gate had been removed.
● Training records showed staff had completed MCA and DoLS training.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect.
- People's appearance was not always considered by staff. People were dressed in clothes where they had spilled drinks on them and staff had not assisted them to change. People wore other items of clothing which were not clean.
- People who were nursed in bed were not always covered and had their door left open.
- On day one of our inspection, one person was restricted to their room and could not leave without asking staff.
- Staff spoke openly about people's care needs in front of other people.
- A relative told us, "I do not think [name of person] is looked after very well. I have to give them a shave, they [staff] never shave them. Last Friday when I arrived they were wet through and in a mess. After an hour, I had to go find staff to ask them to change [name of person] and their bedding. After two hours they [staff] said they would do it."
- Another relative told us, "During a visit, [name of person] was in bed and when I pulled back the bed covers they had no skirt on. At another visit, I pulled back the covers [name of person] had a tee shirt and skirt on in bed.
- Staff prioritised completing tasks rather than assisting people to be as independent as they could.
- We noted some people's oral healthcare was not well managed. A relative said, "[Name of person]'s teeth were missing, and their mouth was dry crusty with remnants of food in her mouth. Their remaining teeth had not been cleaned. I cleaned them, and it took staff long time to find the teeth. When they found them there was no fixing agent. It was the shock seeing their dirty mouth and no teeth. It is undignified and disrespectful." We saw this person had badly fitting dentures which prevented them from eating and drinking comfortably.

These examples illustrate people were not treated with dignity. This is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and some relatives told us staff respected people's privacy and dignity. A person said, "They treat me very well; they provide me with what I need." A relative said, "They [staff] are so nice to [name of person]. They address them by name and are always careful with them. They do knock on their door and they always look clean and tidy."
- People were supported to maintain and develop relationships with those close to them. Relatives told us they were welcome to visit anytime and always felt welcome.

Ensuring people are well treated and supported; respecting equality and diversity

● Even though staff were caring in their approach, we saw staff were task focused in their interactions with people.

● Staff did not always provide timely support to people. We also observed some staff did not always respond to people living with dementia in a supportive and helpful way.

● A relative said, "On several occasions I have been told [name of person] has been fed this morning when they cannot eat food, but they have not given them a drink. What they [staff] say is not always what they do." Another relative said, "They know how to look after [name of person], but they don't always do it. Yesterday, I saw staff on their mobile phone sat at the table instead of helping a person." A third relative said, "They [staff] are so caring and understanding."

● On one unit, we noted a staff member had not realised a person had left the lounge area, potentially putting the person at risk, until the person walked back into the lounge. The staff member said, "I do not usually come here so I do not know the person well at all."

● People and their relatives said staff were kind and caring. We observed a staff member held a person's hand and gently guided them to their room. When they got to the room, the staff member stood back a little while the person read their name on the door and when the person was happy it was their room they let the staff help them to enter the room.

● Compliment cards had been received by the home. These included, 'thank you for taking care of Dad'.

● Staff had completed training on equality and diversity. Although, staff awareness did not always translate to the care we observed which did not uphold peoples' human rights.

● People were supported to access religious services of their choice both in the home and to visit places of worship.

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

● Staff supported people to make some day to day decisions about their care.

● There was no evidence to show people had been involved in making decisions about their care. Although, people said staff knew how they wished to be cared for. A person said, "I do not know about a care plan. They just look after me well." A relative said, "We have talked about it [care plan] and had a meeting. If I wanted I could have more access to it."

● Advocates represent the interests of people who may find it difficult to be heard or speak out for themselves. None of the people had needed to use an advocate recently.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same, requires improvement. This meant people's needs were not always met.

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

- Activities were limited and did not meet the needs of people who used the service.
- There was a list of activities displayed in the home, however, a staff member told us this was no longer followed. There was a lack of stimulation for most people and staff were not skilled in how they interacted with people who were living with dementia.
- People appeared to spend long periods of time in the same chairs in lounges.
- Records of people's care did not always include information about their engagement in meaningful activities.
- People and relatives told us more could be done with regards to activities and stimulation. A person said, "There used to be activities when a lady worked here but she left and there is nobody now. I like to listen to my music and watch TV in my room." A relative said, "I think there could be more, they [staff] do try. They play skittles and draw with but that is all." Another relative said, "There used to be someone who did exercises in chairs. I feel they get no stimulation or one to one attention."

The care and treatment of people who used the service did not always meet their assessed needs This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A staff member told us, they were due to start in the activity coordinators role which would be for three days per week but would still be doing shifts as a care staff member on the other days. They said. "I will be able to put a new program in place once I have my rota. On the days I work as a carer I will put a program in place for the staff to follow."

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

- Some areas of care plans were inconsistent. For example, one person's skin integrity care plan stated, 'I need to be on an air mattress at all times and must make sure my heels are elevated off the bed and I am wearing repose boots'. A staff member told us, "[Name of person] does not wear the boots so we put pillow under their legs."
- Care plans were not always updated when people's needs changed.
- Opportunities to ensure people received personalised care were missed because documents used to gather information about people were not completed. People's life histories had not been completed.
- Some agency staff did not always know how to support people.
- When people became distressed, staff did not always know how to support people to calm down.

● Support and care for one person was not always delivered in line with their requirements.

The registered provider did not design care and treatment with a view to achieving people's preferences and to ensure their needs were meet. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some of people's rights in terms of diversity needs were detailed in their care plans and met in practice. This included cultural needs and religious requirements.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers'.
● The registered manager was not fully aware of the AIS.
● Care plans contained information about people's communication needs and any sensory support or adaptations they required.
● Documents could be produced in any format or language that was required.
● The provider complied with the Accessible Information Standard, a legal requirement to meet communication needs of people using the service.

Improving care quality in response to complaints or concerns
● There was an appropriate complaints management system in place.
● Where complaints had been made, they were responded to in line with provider's policy.
● People and relatives knew how to make a complaint. A person said, "I would go to [name of registered manager] they would sort it out I am positive. I had a problem recently and they sorted it." A relative said, "I have been to the manager about an issue and they were on the ball and sorted it."

End of life care and support
● Most care plans contained a record of people's end of life preferences.
● Some staff had received end of life care training and worked closely with other healthcare professionals to make sure people received coordinated care. A nurse said, "I have completed training on how to provide care at the end of a person's life."
● At the time of inspection there were two people receiving end of life care.
● The registered manager said they had a good working relationship with a local hospice and the palliative team regarding people's end of life care. A visiting healthcare professional told us, "Staff are very engaging and interested in people and have a good end of life care experience."

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Quality monitoring systems were not robust and as a result, people did not receive high quality care.
- The registered manager and provider had failed to identify the risks we found within the home during our inspection. This meant they had not mitigated the risks and as a result, people were at risk of harm. For example, the medication audit had not identified the concerns raised during this inspection with the management of topical creams. Also, the infection control audit had not identified areas of the home which were unclean or demonstrated a risk.
- There was a failure to meet a previous area of concern which demonstrated the service had not improved in this area. Care plans had not been properly monitored and this impacted on staff's ability to provide person centred care. For example, people's care plans did not contain information about their life histories, likes and dislikes or their up to date care needs.
- Information related to people who used service was not always stored securely to ensure the integrity of confidential information. For example, care plans were stored in a cupboard in the nurse's room where both the room and cupboard were left unlocked. The registered manager was going to remind staff about making sure these areas were always kept locked.
- On day one of our inspection a key cabinet was left open. All the keys were labelled with where they were for. For example, bedroom keys. The key cupboard was in an area of the home where there was external access and this door had been left open. This was locked on day two of our inspection.

The provider did not have effective systems in place to assess, monitor and improve the quality of service provided. This was a breach of the Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was aware of their role and responsibilities and submitted notifications to CQC as required.
- The registered manager and staff understood their roles, there was a clear structure in place.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- There was a lack of a consistent approach to person centred care which lead to examples of poor cultural practices in the home.

● The management team had a visible presence in the home and knew people, their needs and their relatives well.
● We received mixed views from staff regarding support they received. A staff member said, "I do not find [name of registered manager] supportive.
● People and relatives told us the management team were approachable. A person said, "Since [name of registered manager] has been the manager it has been a lot better. She has improved things a lot." A relative said, "The management are wonderful, everyone is happy, and nothing is too much trouble."
● People and relatives said the home was clean, staff were caring, and the food was good. Although, one relative said, "The manager is brilliant. Some of the staff are fabulous could not wish for better. However, some [staff] should not be here, no compassion or good training they just don't know how to treat residents unless they are told. A lot more training is required."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The registered manager sought feedback to help maintain and improve standards at the home.
● Resident and relative meetings took place. A person said, "They sometimes have them. The last one was about a trip to the seaside but that got changed we are now going to York instead." A relative said, "We have had meetings, there was one the other week, but I did not go. The ones I have been to are open minded you can say your thoughts."
● A number of residents, relatives and staff questionnaires were completed monthly. The responses were mostly positive.
● Records showed team meetings were held. This gave staff the opportunity to contribute to the running of the service.
● The registered manager had good links with the local community and worked in partnership to improve people's wellbeing. For example, the local primary school children attended the home to sing at Easter and Christmas.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people who used the service did not always meet their assessed needs. The registered provider did not design care and treatment with a view to achieving people's preferences and to ensure their needs were meet.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection detection and control systems were not effective. Not all risks were safely managed. The management of medicines was not always safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken appropriate steps to ensure staffing levels and the deployment of

staff were sufficient to always meet people's needs.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have effective systems in place to assess, monitor and improve the quality of service provided.

The enforcement action we took:

Warning notice issued