Beechcroft Care Homes Ltd

Cary Lodge

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

Summary of findings

Overall summary

About the service: Cary Lodge is a residential care home in the coastal town of Torquay that is registered to provide accommodation with personal care for up to 40 people over 65 years of age. At the time of our inspection there were 13 people living there. The home is set over three floors but only two were being used by people living in the home.

People's experience of using this service:
• People were put at risk of receiving care and treatment that was unsafe. Risks relating to health concerns and behaviours that challenged were not fully assessed. The service had not taken action to reasonably mitigate these risks. Some risks had not been escalated to health care professionals for advice.

• Infection control practises needed improving and the laundry was disorganised which heightened the risk of cross contamination. People's clothes sometimes went missing or were worn by other people.

• Medicines were not always well managed, or administered at the correct times. Staff had not all received training in how to support a person that needed oxygen to help them to breathe.

• There were not enough staff in key communal areas to ensure people were safe and to meet their social needs.

• Activity provision was poor. People told us they felt bored. We saw some interactions between staff and people that were not respectful or dignified. Other interactions were caring and kind.

• Oversight of the running of the service was inadequate. Quality control had not picked up on some of the issues we found on this inspection and some issues were repeated from our last inspection.

• However, we did see some improvements. Consent documents had been more thoroughly completed, and the service had made efforts to improve care planning.

• Understanding of safeguarding people had improved and recording of falls was more detailed and showed a level of analysis the service could learn from to prevent reoccurrence.

Rating at last inspection:
At our last inspection on 12 and 18 June 2018 we rated the service Inadequate. The report was published on 10 September 2018.

Why we inspected:
This was a scheduled inspection based on the previous rating. When a service is rated Inadequate it is inspected again within six months to see if improvements have been made.

Enforcement:
Enforcement action will be published at the end of this report once the provider has had adequate time according to our enforcement process to respond to our proposals.

Follow up:
The overall rating for this service is Inadequate. This means that it remains in special measures.
The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Cary Lodge

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. 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.

Inspection team:
The inspection team consisted of two adult social care inspectors, one assistant inspector, one inspection manager and one 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. In this case, the area of expertise was older people and dementia care.

Service and service type:
This is a residential care home that provides accommodation and personal care to people.

The service had a manager registered with the Care Quality Commission. This means that 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 held regarding the service, we looked at notifications we received since the last inspection. Notifications are when the service tells us of an important event. We also reviewed recent safeguarding records and spoke with the local authority quality improvement team who had been supporting the service.

During the inspection process we spoke with six people living in the service. Nine staff members including the registered manager, deputy manager, staff training lead and cook gave us feedback. We also spoke with seven relatives during the inspection process and received feedback from three health professionals.

We looked at care records for seven people, this included risk assessments and needs assessments and daily recording of care provided. We looked at consent documents, falls records, four staff files for supervision and recruitment and training. We also looked at Medicine Administration Records (MAR) and how medicines were received, stored, administered and disposed of.

We spent time in the communal lounge throughout the day observing how staff interacted with people and also conducted an informal observation of breakfast and a SOFI during the lunch time meal. SOFI, or short observational tool for inspection is a way of observing care provided to people who may struggle to communicate their experiences to us.

We walked around the home and saw the kitchen and all communal areas and bathrooms. We saw the bedrooms of six people living in the home and checked the upstairs windows in communal areas for fire and safety reasons.

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 risk of avoidable harm. Some regulations were not met.

At our last inspection in June 2018 we rated the service Inadequate in the safe domain. We found breaches in legal requirements as set out in the Health and Social Care Act 2008. We had concerns that people were placed at risk of avoidable harm and found evidence there was a breach of Regulation 12 regarding medicines and the assessing and mitigation of risks. We also found a breach of Regulation 18 regarding staffing levels. At this inspection we found improvements had been made in some areas. For example; medicines were no longer potted up for night staff. However, we found additional concerns with the safe management of medicines, moving and handling practises, infection control and staffing deployment. Improvements were not sufficient and we found people were placed at risk of avoidable harm and the service was still in breach of Regulation 12 and Regulation 18.

Assessing risk, safety monitoring and management
• Equipment was not always used in a safe way. We received feedback that on some occasions people requiring the support of two staff to move with the support of a hoist were only supported by one staff member. The registered manager told us this did not happen. We did not witness people being supported with the hoist by lone staff members during the inspection.
• One person had a serious health condition that affected their breathing. There was no detailed risk assessment with staff instruction in place for this regarding how often and in what way they could be supported to safely use their oxygen. This person used oxygen to help them breathe, the safe use of oxygen was not sufficiently detailed in this person's care plan or risk assessment as it should be to manage the risk associated with the use of oxygen.
• One person had a skin tear on their leg. This was not recorded in the persons care plan and had not been followed up.
• We observed and had to intervene when we saw one person about to fall out of their chair. They had been left by staff propped up with a pillow, as described in their care plan. The care plan regarding moving and handling and risk assessment for falling we looked at failed to take account of the person's tendency to lean forward out of their chair. This tendency to lean forward was noted elsewhere in the person's care plan but the information was inconsistent and took time to find. This placed the person at risk of a fall.
• We observed in the communal lounge, two examples where staff failed to put brakes on wheelchairs and two examples where foot plates were not used. People were at risk of injuring their feet when being assisted in the wheelchair.
• Risks associated with one person's dementia, and how this affected them, were not fully assessed or mitigated. Their care plan did not contain consistent information on how staff could practically de-escalate situations or support the person to calm. One risk assessment referred to the de-escalation plan for guidance. The de-escalation plan had as its action "To reduce any signs of agitation and de-escalate any challenging behaviour. For staff to record any changes." This was not adequate instruction on how to support this person around the risks they faced and posed.

• One person was living with a long-term health condition affecting their breathing. We saw the person was prescribed three inhalers to manage their condition. The person had refused these medicines for several days prior to the inspection. Their care plan said they 'occasionally' refused their inhalers and staff were to 'encourage' them to take them. There was no protocol or risk assessment in place for when to escalate concerns and when to seek medical advice. There was no assessment of what the impact and risks of the refusal of the inhalers could be. There was no specific care plan for the condition, and only one mention of the medicines being refused in their daily notes for the preceding five days. The refusal had not been reported in the morning handover of information between staff. We saw the person did not receive their inhalers again on the morning of the inspection as they were asleep until lunchtime. We raised this with the registered manager as we were concerned for the person's wellbeing.

Using medicines safely
• People did not all receive their medicines safely, as prescribed or in accordance with the service's policy and procedure for medicine administration. We observed one person missed a dose of their antibiotic, and another person was administered pain medicine without the required four-hour gap between administration. Other people were given medicines straight after breakfast when the instructions stated they should be administered 60 minutes before or after a meal.
• One person was prescribed Oxygen therapy; however, this was not detailed on their medicines administration record (MAR chart). The service's medicines policy stated an entry for Oxygen, "Should be made on the MAR chart, the same as with any other medication."
• Medicines sent to the service from the supplying pharmacy for the current month had not been entered onto the service's MAR charts, which had been in use for 15 days. This was contrary to safe practice and home's policy on the safe management of medicines.
• Prescribed creams were not all dated when opened, so it was not possible to see when creams should be discarded as no longer safe to use.
• The prescription label of one prescribed and open cream in the medicine cupboard was not in place, so it was not possible to see for whom it had been prescribed. We observed a staff member using one person's prescribed thickening agent to thicken their hot drink, and then using the same thickener for another person. Each person should have their own prescribed medication used specifically for them.

Preventing and controlling infection
• People were placed at risk from poor infection control practises that evidenced the service was not preventing, detecting or controlling the spread of infections sufficiently.
• Staff wore gloves and used aprons, However, we saw a person's continence pads left in a tub in a communal bathroom with cleaning apparatus and a dirty mop and bucket leaning against dry food storage in the kitchen.
• Equipment was not always adequately cleaned. For example, we saw a wheelchair encrusted with food and a spacer for use with an asthma inhaler left in a communal area with medicine residue in it where it had not been cleaned.
• The laundry posed infection control risks with surfaces unable to be cleaned due to large piles of items. Dirty and clean items were stored in close proximity posing a cross contamination risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing
• Staff deployment was not effective in ensuring people were safe and had their needs met. There were 13 people living in Cary Lodge at the time of our inspection over two floors. Six people needed two staff members to support them to move or with personal care. The registered manager told us there were three

staff on in the morning, three in the afternoon and two at night with a staff member to support with breakfast and lunch if required. Although the provider told us the decision had been made that people could only sit in the dining room or the lounge, not both, we saw people spent time in both the dining room and communal lounge at the same time. If two staff were supporting one person with personal care and one staff member was in the dining room outside of breakfast and lunch times, there were no staff in the communal lounge to spend time with people and ensure they were safe.
• We had to intervene and go and find staff as we were concerned about one person left alone in the lounge. The person was assessed as being at "Very high risk of falls." One of the control measures identified on their risk assessment was "To be placed in the communal areas during the day so that staff can monitor and intervene should she start to become agitated to stand up. We try to ensure that there is always one member of staff in the lounge." Throughout the day we observed there were no staff on several occasions in the lounge as they were busy elsewhere in the service.
• We observed people being brought to the lounge in wheelchairs in a large group from the dining area. Staff were rushing and wheeled people into the lounge and left them in the wheelchairs whilst going to get other people. One person was left for 22 minutes in their wheelchair facing a wall whilst staff were busy with other people.
• Staff said they often felt rushed. Care we observed in the communal lounge was focussed on the care tasks being provided rather than the experience of people, and staff did not have the time to sit with people.
• Most relatives we spoke with said at times they had to go and look for staff members because they had not seen one in communal areas when visiting. One relative said, "Things appear slightly better now, but there still seems to be too few staff on duty." The service sent us two letters which showed two relatives were happy their relative was safe and having their needs met.
• Staff told us they knew other staff members who supported people to move using the hoist by themselves as it was quicker and there was often no staff member free to help.
•For one person the service had assessed them as posing a risk to themselves, staff and others and assessed the risk as likely to happen and the impact as significant. A control measure identified for this person was, "Lounge and dining area to be monitored at all times." We observed this was not the case and throughout the day the lounge was left for periods without being monitored. We observed there was a whole hour where the lounge was not monitored by staff when this person was present.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; recruitment; medicines storage
• Staff had been provided with training in how to safeguard people from abuse. They could tell us what they would do if they were concerned about a person's welfare.
• The registered manager understood how to make a safeguarding referral to the local authority and when it was appropriate to inform the CQC.
• Staff files showed checks had been made prior to employment to see if staff were suitable to support people in a care setting.
• Medicines were stored in a lockable cabinet chained to the wall. Staff were patient when administering medicines to people.

Learning lessons when things go wrong
• The service tracked falls and analysed falls information to try and prevent re-occurrence, although this level of oversight did not extend to the issues we picked up on inspection regarding falls and the monitoring of people at risk of falls.

Premises safety

• Checks were made on the environment to pick up any health and safety concerns.
• Maintenance and repairs were followed up promptly and there was a rolling programme of improvements.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection in June 2018 we rated the service Inadequate in the effective domain. We found breaches in legal requirements as set out in the Health and Social Care Act 2008 relating to consent, staff training and people waiting long periods for food. At this inspection we found improvements had been made in these areas and the service was no longer in breach of legal requirements relating to this domain. This domain has now been rated requires improvement as there were still some improvements to be made.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• There were assessments in place which detailed people's needs for the most part. We identified some gaps on this inspection relating to individual preferences and assessment of risks but there was an improvement in this area from the last inspection.
• Recently published guidance on preparing food of different textures for people who found it difficult to swallow was visible in the kitchen for the cook and other staff to refer to. This showed the service was making efforts to keep up with best practise guidance.
• The service was using an electronic recording system to record when care had been provided and it raised alerts as to when it was needed or overdue. This meant the ongoing day to day assessment of peoples needs was better recorded.

Staff support: induction, training, skills and experience
• Staff were supported through supervision and appraisals.
• Staff had received training in areas the service identified as being essential to meeting people's needs. This included first aid, moving and handling, infection control, health and safety and dementia. There was a plan in place to develop training in areas the service considered more specialist, such as continence and catheter care, swallowing and dysphagia, epilepsy and diabetes. We asked the registered manager about this and they said they had recently enrolled four staff to train to achieve a diploma level course in care.

Supporting people to eat and drink enough to maintain a balanced diet; accessing healthcare services
• People were supported to eat and drink where they needed it. Where people had pureed meals due to a choking risk, food items were separated out to make it more appetising.
• Drinks were offered at particular times during our inspection but between these times we did not see staff offering drinks. There were no drinks or fruit available in communal areas for people to help themselves to if they were hungry or thirsty.
• Appropriate referrals to healthcare services were made.

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

• The service had arranged for bedroom doors to be covered with a different colour film layer for each door so they were more easily identifiable to people and looked homelier. This was in progress whilst we were inspecting the service.
• There were some signs around the home directing people to communal areas. However, these were not consistently in place and we found the sign for the lounge in a bathroom, and one sign for the toilet did not lead to a toilet that people could use. This would have been confusing for people with dementia looking for a toilet.

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). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• The service had made appropriate applications through the DoLS process.
• The registered manager had a good understanding of consent and the MCA and staff were supported to attend training in this area.
• We saw evidence of best interests decisions being undertaken and recorded. However, best interests records were not in place for the use of a lap belt used by one person in a wheelchair. Since the inspection the registered manager had acted to remedy this.
• Staff did not always seek consent from people before delivering personal care. For example, two staff supported a person to move from a chair into a wheelchair using the hoist. Neither staff member asked the person for consent before moving them. We fed this back to the registered manager as part of our wider concerns around moving and handling practise and asked them to look into it. We also fed back that we saw some good seeking of consent from some staff members.

Inadequate

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

At our last inspection in June 2018 we rated the service requires improvement in the caring domain. We found breaches in legal requirements as set out in the Health and Social Care Act 2008 relating to treating people with dignity and respect. At this inspection we found repeated concerns with the way people were treated and observed several examples where people were not treated with dignity and their human rights not acknowledged in this area. The culture of care that the registered manager wanted to promote was not always embodied in the care that we saw provided to people.

Respecting and promoting people's dignity and treating them with respect
• We saw one person being pushed back in the hoist by their forehead, we saw one person being helped to upright with a rough shove, and another person had their leg lifted and then dropped on to a foot pedal. These interactions all took place in the communal lounge and during this period staff were not talking with people about what they were doing or acknowledging the people.
• We observed one person, who was living with dementia, in a communal area for an hour. During this time staff did not speak to or interact with them at all. They entered the room and did not acknowledge the person.
• One person had an attachment to a comfort or empathy doll, and was seen throughout the inspection interacting with it in a very positive way. We observed a staff member pick the doll up by the leg and hold it upside-down before passing it to the person, and on another occasion, pick it up by its head in front of the person. This was disrespectful to the person's attachment and showed a lack of respect for their feelings and property.
• We observed one person waiting for assistance to move from a wheelchair to an armchair, they were upset, waving their arms, crying and verbally expressing their distress. Staff came in and out of the room and assisted other people and did not reassure this person for ten minutes.
• Staff and relatives told us of occasions where people had been left wet, uncomfortable and in need of continence support.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the service sent us feed back from questionnaires relatives had completed. This showed that some relatives thought their loved one was treated with respect.

Ensuring people are well supported; equality and diversity; promoting independence

• People were encouraged to eat without staff support where appropriate, to promote their independent eating skills.
• We saw positive caring meal time interactions where staff sat with people and were patient and engaged them in conversations. Support at breakfast time was gentle and staff were patient with people.
• Staff told us they cared about people.
• Staff had attended training in equality, diversity and human rights but understanding of this was not evident in all care provision we observed.
• Staff celebrated people's achievements, for example eating a good meal for someone whose appetite was often poor.

Supporting people to express their views and be involved in making decisions about their care
• Relatives told us they were informed if their family member had experienced a fall or became unwell. Some relatives said they were not updated when they would like to be on care planning or some decisions about care.
• We saw where efforts had been made to contact some relatives regarding care planning.
• The registered manager said, "We are guided by them (people) the care plans we have on people aren't perfect, we ask people how they want things, we have lots of people who can tell you but we try and speak to family and other representatives too."

Inadequate

Is the service responsive?

Our findings

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

People's needs were not always met. Some regulations were not met.

At our last inspection in June 2018 we rated the service inadequate in the responsive domain. We found breaches in legal requirements as set out in the Health and Social Care Act 2008 relating to person centred care. At this inspection we found repeated concerns relating to people not having access to sufficient social interaction or meaningful activity to promote their wellbeing.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• The service used a bathing routine sheet which noted which days people were to be bathed. The sheet was referred to in the handover when a staff member asked, "Who is due to be bathed today?" and was on display in a staff office. Records showed people were not being bathed often, one person was only recorded as being bathed or showered four times in 14 weeks, another person three times. We asked the registered manager about this and they said, "Some people are bathed more frequently and some less often because they are difficult to bathe." When we asked the registered manager if everyone was bathed as much as they would like to be they said, "Possibly not." This was not person centred, people were only listed for bathing support one day a week and their preference was not accounted for.
• Staff fed back the care could be more person centred and the service did not focus on people as individuals.
• We did not see evidence that information for people had been put into an accessible format.
• There was a hairdresser visiting on the morning of the inspection and a craft activity in the afternoon. People were not supported to spend their time doing things that were important to them or they were interested in. This was an issue identified at our last inspection. One person said "There's not much to do here. You just have to pass the time for yourself", and another said, "There's little to do here. Occasionally in the warmer weather you can go outside, but that's about it". People's preferences to be kept busy and go out were not being met.
• One person did not have their glasses on, their care plan identified they saw double when not wearing glasses and this was distressing for them. When we asked, the registered manager told us the glasses had broken the day before the inspection. There was no message on the handover to inform staff the person could not see and no staff identified on the handover or elsewhere to arrange repairs. This was an issue at the previous inspection and showed a lack of person centred care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service had made efforts to review people's needs and improve on care planning. The electronic system was still being updated with all care documents.
• We saw some interactions during the lunchtime meal where staff knew what people's food preferences were and where they liked to sit.

• There was a call bell system in the service that staff responded to promptly when people pressed the bells for assistance.

Improving care quality in response to complaints or concerns
• The service had a complaints policy and procedure.
• Complaints were investigated and responded to. Actions resulting from complaints were recorded.
• Relatives told us they felt comfortable complaining and would approach the registered manager if they needed to.

End of life care and support
• The service had an end of life policy. At the time of our inspection nobody was receiving end of life care.
• Some people's end of life wishes had been recorded and efforts made to find out other people's wishes from family members.

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.

Leadership; quality of care, culture and management of risk
• Care was not always person centred and did not reflect the person-centred values the registered manager told us about. The registered manager was unaware that staff did not provide care that was in keeping with a culture they were trying to promote. The service failed to meet people's social needs. This impacted on their wellbeing and we saw people upset and distressed.
• Several times throughout the day we found a lack of staff presence in communal areas which placed people at risk of harm. We had to intervene we were so concerned, and go and find a staff member. The oversight of how staff were deployed to best meet people's needs was inadequate.
• We found significant failings in how staff treated people and a culture of dignity and respect was not fostered within the service. The registered manager and provider were aware of these issues as they had arisen at our last inspection and were serious enough to constitute a breach in legal requirements. Despite this, there was a failure to effectively assess, monitor and improve the experience of people living in the service regarding their dignity and respect. These failings impacted on people's wellbeing and quality of life.
• The service had received feedback on where concerns lay from our last inspection and had received ongoing support from health and social care professionals. Despite this, we found significant repeat concerns to suggest there was a failure to act effectively on this feedback to improve the quality of service provided to people.
• We found a repeated failure to operate a quality system that could identify, assess, monitor and mitigate risks posed to people. For a person who at our last inspection presented behaviour that posed a risk to themselves, staff and other people, the risk assessment and actions were not sufficiently detailed, consistent or effective.
• The register manager was unaware of the issues we observed in communal areas. We had to ask them to make a safeguarding referral we were so concerned about one person, this showed the supervision of staff on shift to ensure best practise, was not in place.
• People's needs and rights were often overlooked because there was a lack of understanding and leadership around how to promote an equality agenda for older people with sensory, mobility and dementia needs.

This was a breach of Regulation 17 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 registered manager and staff struggled to tell us how they were considering people's equality

characteristics.
• Some relatives told us they were involved in decisions and planning around their family members care, others told us decisions were made without involving them.
• Staff said they felt more supported in recent months and the registered manager was approachable. However, some staff told us they did not feel supported when they raised concerns and were not fully confident they would be protected under the whistleblowing policy.

Continuous learning and improving care
• Despite the widespread concerns we found at this inspection we did see several improvements in the service. Recording had improved, falls were being more effectively monitored, and care plans and consent documents were more accurately completed.

Working in partnership with others
• The service worked in partnership with key health and social care professionals with an aim to achieve positive outcomes for people.