Farrington Care Homes Limited

Lyme Regis Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Lyme Regis Nursing Home is a nursing home providing personal and nursing care to up to 27 people. The service provides support to older people with a range of nursing needs; some of the people living in the home are living with dementia. At the time of our inspection there were 25 people using the service

People's experience of using this service and what we found
People lived in a home that had undergone substantial management and staff changes. The last registered manager had left in November 2021 and since this time there had not been stable management. The turnover of staff had been high with agency staff providing the majority of hours. A new manager was appointed during the course of this inspection.

People told us the staff were kind and helpful we saw this was the case. We also saw that they were busy and there was a focus for staff on getting through tasks. People did not always receive the right care for them. Assessments of need and the resultant care plans did not contain detail about people's preferences for how their care was delivered or detail about their care.

People lived in a home where risks were not effectively or sufficiently managed and this placed them at risk of harm or injury. The Fire Service had issued a safety order. The provider had three months to make the improvements required by the Fire Service. Risks associated with environment including cleanliness were not managed sufficiently. Risks people faced related to the integrity of their skin were not safely managed. People who had moved into the home at the start of February 2022 had not had the risks they faced assessed or personalised plans of care, to mitigate these risks, developed. People did not always receive their medicines as prescribed. These issues were not all addressed in a robust and effective manner during our inspection.

Staff understood how to wear PPE appropriately. People received visitors safely.

There were not always enough staff deployed in the home. The staff had mixed opinions as to how well supported they felt. The oversight of training and induction improved over the course of our inspection. At the start of the inspection, people were being care for by staff who had not had appropriate inductions and in some instances, they were working more hours than their visa allowed. This was with the agreement of the providers.

People felt safe and were supported by staff who understood how to report safeguarding concerns.

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 were not embedded to support safe practice.

Where people could not consent to live in the home, Deprivation of Liberty Safeguards had not always been applied for appropriately.

People told us they enjoyed the food. Mealtimes were not always a relaxed and pleasurable experience due to maintenance work. People's weights were not always being checked within the time frames that reflected the risks they faced.

Recording was not sufficient to monitor risk, or the quality of care people were receiving.

People had not been asked for their views about changes in the home and people and relatives had not been kept up to date with management changes.

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 good (published 5 August 2021).

Why we inspected
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. This included checking the provider was meeting COVID-19 vaccination requirements.

The inspection was prompted in part due to concerns received about oversight, staffing and environmental risks. We have found evidence that the provider needs to make improvements. We received further information of concern and a decision was made to widen the scope of the inspection.

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

This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection, that rated those key questions, to calculate the overall rating. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staffing, risk management, person centred care, the application of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and oversight at this inspection.

Please see the action we have told the provider to take related to oversight, staffing, person centred care and the application of the MCA at the end of this report.

We have taken enforcement action requiring the provider to ensure people receive safe care and treatment and are protected by DoLS.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Lyme Regis Nursing Home

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.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Lyme Regis Nursing Home 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. Lyme Regis Nursing Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager 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 from, and about, the service since our last inspection. This included feedback from the fire service and the local authority and clinical commissioning group (CCG) quality improvement team. 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 our visits to the home we observed the care and support people received. Some people living in the home did not use words as their main form of communication. We spoke with eight people who were able to tell us about their experience of care. We also spoke with friends, or relatives, of five people. We spoke with three managers, including the new manager, three representatives from the provider organisation and ten members of staff. We asked an acting manager to invite all staff and the friends and relatives of people living the home to share their experiences either through our website or by phone. We received comments from a staff member and a relative in response to this. We reviewed records related to the care and support of ten people. We also reviewed training records, meeting minutes, staff communication and documents related to the oversight of the home. We received feedback from health professionals who had contact with the home.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, learning lessons when things go wrong

- The provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. People admitted to the service in February 2022 did not have comprehensive risk assessments, or care plans, in place to ensure care and support was delivered safely. For example, the assessment completed for one person showed they were a "very high risk" of developing pressure ulcers. There was no care plan in place to direct staff with actions to reduce the risk for this person.
- Monitoring records and risk assessments were not up to date and did not reflect people's current needs and risks. For example, several people had pressure relieving mattresses in place to reduce the risk of skin damage. We looked at the setting for seven mattresses and found four were not set to the appropriate setting. There were no instructions in care plans to guide staff about individual settings. There were no arrangements in place to ensure mattresses were checked regularly to ensure settings were correct.
- These shortfalls put people at risk. We discussed this with the management team on the first day of the inspection to ensure action was taken to keep people safe. However, on the second day of the inspection, three mattresses were still not set to an appropriate pressure. This placed people at risk of further skin damage.
- It was not always possible to tell if people had been helped to reposition to protect their skin. Three people had long gaps in their repositioning records. We visited one person who was lying on their back at 10:50 am. Their repositioning record was last completed at 7:10am and stated they had been moved to their back. No other records had been made since this time. We visited them again at 13:00 they were still on their back and no records indicated any care had been provided in this time. Two other people's records indicated gaps of 12 hours without repositioning support.
- A visit by the Dorset Local Authority Quality Monitoring Team on 25 January 2022 had identified risks and prompted a visit by the Fire Service. A Fire Safety Order was issued requiring the provider to make improvements within three months.
- One person did not have a number or name on their door, which could risk delays in the event of an emergency evacuation. We highlighted this to the management team. On our second visit we were told this had been ordered. When we visited again this action was still not completed.
- Environmental risks were not managed safely. Contractors were not sufficiently monitored and they left an electrical cable trailing on the floor putting people at risk of falls. One person told us: "It is a bit of a trap". Two drills and a sealant dispenser were also left unattended. The gate protecting people from the stairs was left unlocked on frequent occasions. The sluice door was left open giving people access to an area with numerous hazards.

Risks were not always assessed, monitored safely and mitigated. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other potential environmental health and safety hazards had been addressed. For example, the risk of burns or scalds from radiators or hot water. Windows checked by us had been restricted to prevent falls.
●The provider was ensuring recommendations made following a recent Fire Service visit were being actioned and was acting to address environmental issues identified by a local authority and CCG monitoring visit.

Using medicines safely
● Medicines were not always safely managed. Guidance was not available for staff to follow when medicines were prescribed to be given "when required".
● The care plan for one person stated they were prescribed a certain medicine when required to manage an underlying health condition. The medicine was stored securely in the medicines room. However, the person's current medicine administration record did not have a record of the medicine or instructions of how it should be used. The nurse in charge checked with the GP. Although the medicine had not been used in some time, it was required to ensure the person's underlying condition was safely managed. This omission had not been identified during regular medicines management audits.
● Out of date medical equipment was being stored in the medicines room. The nurse in charge immediately removed the equipment once brought to their attention. This also had not been identified during regular medicines management audits.
● The portable appliance testing for one piece of medical equipment had not been completed since 2017. This also had not been identified during regular medicines management audits.
● Not all prescribed creams were securely stored. We found one in a communal bathroom.
● Some medicines had not been signed as administered and there was no explanation recorded as to why. For example, one person had not received medicines prescribed to treat epilepsy. Cream charts were also not signed consistently. One person who a nurse identified as having prescribed creams did not have any records available related to their administration. Another person who had a cream applied by staff also had no recording for their creams. This meant we could not be assured people were receiving their medicines as prescribed.

Systems were not robust enough to demonstrate medicines were effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored safely and safely disposed of when no longer required.

How well are people protected by the prevention and control of infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. A visit by Dorset Quality Monitoring Team (local authority and CCG) on 25 January 2022 had identified that areas of the home were not clean. The provider had organised a cleaning company to undertake a deep clean. There work had not been sufficient, and parts of the home were not clean, including people's bedrooms. We found dust and debris on windowsills; radiators and furniture. Some carpets were heavily stained. There had been a shortfall in cleaning staff over the past weeks. No cleaning schedules have been completed since January 2022 and there was no record of frequently touched points being cleaned regularly. However, care staff said this was done by them when there were no cleaning staff on duty. Areas of the premises needed attention to improve infection prevention and control, for example the laundry and sluice areas. This work was part of an existing improvement plan in place. A bactericidal cleaner had been decanted into a spray bottle on the cleaning trolley but was not labelled. The person responsible for the cleaning on the first day of the inspection was not aware of to use it. Some bed rail covers had been breached, with small tears and holes apparent. This presented an infection control risk and

had not been identified in the Infection Prevention and Control (IPC) audits. The management team said new covers would be ordered.
● We were not assured that the provider's infection prevention and control policy was effectively implemented. The housekeeping IPC audit completed in February 2022 showed only parts of the audit had been completed with several blank areas. For example, daily room checks; housekeeping cleaning schedules; feedback from people living at the service; weekly room checks were blank on the audit. Checks on hazardous cleaning products showed no action needed but we found an unlabelled product and cleaning staff unsure what it or how to use. The audit showed no actions were highlighted in relation to the cleanliness of the premises or individual bedrooms, which we found dirty and dusty.

Infection prevention control measure were not robust. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Two new staff had not completed IPC training to ensure they worked safely. The management team confirmed infection prevention and control refresher training was planned for all staff.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely. A member of kitchen staff was not wearing a mask on the third day of our inspection. The manager told us they were addressing this.
● We were assured that the provider was accessing testing for people using the service and staff.
● The provider was facilitating visits for people living in the home in accordance with the current guidance.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.
● The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.
● The service was meeting the requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Staffing and recruitment
● We received mixed feedback about staffing levels. People said staff were helpful, but two people told us they had to wait for attention at times. One said, "They (staff) come as quickly as they can. It can be 10 minutes or more, but they are busy". Another person explained that important little things were missed due to staff shortages at times. They said, "…things are missed, simple things like we've got no tissues. The place isn't as clean as it was". They added, "Staffing is sketchy especially at weekends."
● People and relatives also spoke about the high turnover of staff more recently at the service. One said, "The place has changed terrifically. Nearly all the staff I knew have left. We've lost lots of good staff". Other comments include, "The only thing is we don't have the same staff here. There have been lots of changes" and "The only disruptive thing is the staff turnover".
● We discussed staffing with the acting manager, and they acknowledged that staffing was difficult and that there had been substantial turn over with the majority of care staff hours delivered by agency staff. On the first day of our inspection three agency staff were working more hours than their visas allowed to ensure

minimum staffing levels were maintained. This put the home at risk of not being able to ensure adequate staffing levels to maintain safety.

There were not sufficient staff with appropriate skills and experience deployed in the home. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● More agency staff were employed before the end of our inspection and the new manager had started to appoint permanent staff.

Systems and processes to safeguard people from the risk of abuse

● People we spoke with said they felt safe because staff knew them, and they trusted staff. Despite the high turnover in staff recently, people told us, "Things are ok. I am happy enough and have nothing to be concerned about"; "The staff are good to me" and "The staff are lovely, and they are looking after me".

● Staff confirmed they had completed training to help them recognise and report any poor practice or concerns relating to abuse. However, training records shared with us did not include confirmation of safeguarding training for staff. The management team were reviewing staff training needs and a training matrix for 2022 was being developed to ensure staff received the provider's mandatory training.

● Although staff knew to report any concerns to the person in charge, some were not aware of external agencies to contact should they have concerns about people's wellbeing or safety. This was an area for improvement.

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 good. At this inspection the rating has changed to inadequate: This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had not been sufficiently assessed. Four people had moved into the home in February 2022. Assessments had been carried out to determine if the home could meet their needs. No further assessment had been carried out to determine people's preferences or the detail of their needs. For example, areas of one person's short-term care plan were blank, including psychological and emotional needs; cognition and behaviour. This person frequently expressed anxiety and distress, calling out and requiring a lot of reassurance. Without clear instructions, there was a risk that staff would not provide consistent and appropriate care. Daily records showed not all staff had a good understanding of the person's behaviour describing their distress as 'annoying' and 'noisy'.
- Care plans did not reflect individual assessment with numerous examples of text being duplicated between people leading to errors such as: assessments had taken place before they were admitted; reference to hospitalisation in a different part of the country and incorrect emergency contact details. The care plans had not all been printed and were not readily accessible by the staff providing care.
- Care plans related to support needed for oral care and foot care were almost identical for five people. There was no indication of individual preference regarding time of day people liked to have support with oral care, the type of brush they liked or whether they would like to use a mouth wash. Information about foot care referred to regular toenail cutting but did not reflect preference or need related to this frequency. The care plans did not reflect individual need or national good practice guidance related to oral care.
- Care delivery records related to oral care had large gaps. We noticed most people's mouth's did not appear dry or dirty. However, one person did at 11:37am on the second day of our inspection. We asked a staff member who could not confirm if oral care had been provided to the person and told us they would address this.

People's needs were not adequately assessed, and care was not delivered in line with their needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Systems were either not robust enough to demonstrate known risks were effectively managed. For example, food and drink record charts were in place for some people where they were considered as a high risk of being malnourished. Two people's charts had substantial gaps in recording and did not provide necessary detail. For example, one person's records indicated 'spoonfuls of soft food diet' but did not indicate what this was. Daily fluid intakes had not been tallied to alert staff that people may need additional

support with diet and fluids.
● Kitchen staff did not have up to date information for all people and records did not utilise nationally recognised terminology defining the texture of modified foods and thickened liquids. This put people at risk of harm.
● People did not always experience a peaceful mealtime due to noise made by contractors. This is important because disturbances can reduce the chances of people eating and drinking enough. This was identified as an issue by the local authority two days before our third visit. It was repeated when we visited and was not addressed until raised by an inspector. One person told us they would like the noise to stop whilst they ate.
● The monitoring of weights had improved but was not robust. People at risk of weight loss had not all been weighed weekly in February. This placed people at risk of harm.

The risks associated with eating and drinking were not adequately assessed, monitored or mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Four people had moved into the home in February 2022. When we visited their consent to their care had not been sought on our first or second visits.
● Mental capacity assessments had not been consistently completed and consent sought for care and restrictive practices. These processes had not always been completed correctly. One person had an MCA assessment completed that did not identify the decision it related to. This meant people were at risk of receiving care and treatment that did not reflect their wishes or was not delivered in their best interests.
● This was particularly evident where people's dementia had progressed and the impact of this had not been considered appropriately within the framework of the MCA. One person's care plan stated that if they became unable to make choices the nurse in charge would determine the way forward. There had been a change in their ability to make decisions and no action had been taken.
People's consent to their care and treatment had not been sought within the framework of the MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed the omissions related to consent with the clinical lead and the new manager. They

acknowledged this was the case and told us they would address it.

● Where people did not have capacity to consent to living at Lyme Regis Nursing Home to receive their care and treatment the law requires that a Deprivation of Liberty Safeguard be applied for. This would ensure people are not detained unlawfully in the home.
● When we visited in February it was acknowledged that three of the four people who had been admitted in February may need these safeguards. They were applied for after our second visit.
● During our second visit one person became upset and told us that they wanted to be discharged. We referred this to the nurse in charge. On our third visit they told us they needed to run away and were considering harming themselves as they were unable to leave. We shared this with the manager and nurses. This person did not have a DoLS in place. There care plan stated they did not have capacity but did not have a DoLS. The clinical lead told us that if they tried to leave, they would stop them. This indicated a lack of understanding of legal framework and the importance of the human rights protection provided by a DoLS.
● The clinical lead also acknowledged that another person whose care plan stated they did not need a DoLS would need this to be reconsidered.

People were deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The new manager assured us they would review the implementation of the MCA and DoLS. We have not been able to review the impact of these actions at this inspection.

Staff support: induction, training, skills and experience
● There was mixed evidence related to staff induction and training. When we visited the home in February 2022 the training matrix was not completed consistently. The acting manager acknowledged this and told us that it was being reviewed to identify when refresher training is due.
● At the start of our inspection we were not able to evidence that agency staff had received an induction. We were told that one of these staff had been due to be inducted on the day we visited. They had worked two full day shifts prior to this. They told us they had received guidance about aspects of the role. However, they had been provided with an unlabelled cleaning product and were unaware what was in it or how to use it. The induction for the role they were carrying out was not sufficient.
● There was no record of an induction available for any of the staff at the start of our inspection. The new manager had implemented a recorded system by our third visit.
● Staff told us they had received training to carry out their roles. An experienced member of the team described how they were supporting new staff.
● The new manager had also started all staff on the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. Training sessions had been booked and workbooks provided to staff.

Adapting service, design, decoration to meet people's needs
● There was substantial work going on to improve the environment. The provider explained they were investing in the home. An action plan had been developed to ensure that all issues were addressed.
● The new manager was working to the action plan developed after a monitoring visit by the CCG and local authority.
● Actions to improve the environment had a positive impact on people's lives. The hairdressing room had been used for storage. This was emptied and a hairdresser brought in, we received feedback that this had

led to a buzz in the building as people complimented each other on their hair dos.

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

- We received feedback from health care professionals that the changes in leadership in the home had led to delays in discharge for people.
- The GP visited a person who had become unwell. They told us the staff had requested this for them.
- The advice and guidance from healthcare professionals was not always clear in people's care plans. This was an area for improvement.

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

Well led
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The previous registered manager had left the service in November 2021. At the start of our inspection there had been five managers running the home since this time. During our inspection a new manager was appointed to the role. The lack of consistent leadership had resulted in high staff turnover and failure to ensure quality monitoring systems were operating effectively. This meant risks, to people and staff, were not identified or responded to.
- Areas for immediate action due to their impact on people's safety were not addressed in a timely manner. This continued to place people at risk.
- The provider and acting managers were aware that they were enabling staff to work more hours than their visas allowed. This put individual staff at risk of legal repercussions, and this put people at risk of not having sufficient staff.
- Although the provider had audits and some risk assessments in place, they were not effective and had not identified issues we highlighted at this inspection. For example, medicines audits and infection prevention and control audits had not identified the issues we found.
- Oversight had not ensured that statutory obligations were met. The risks people faced had not been assessed and their consent to care had not been sought. Deprivation of Liberty Safeguards were not applied for.
- Breaches of regulation identified at this inspection mirrored those found in our inspection published in August 2019. The improvements made under the last registered manager had not been sustained and unsafe working practices had become embedded again.
- Accurate, complete and contemporaneous records had not been kept in respect of each person living at the service. Language used in the daily notes was subjective and judgemental on occasion and showed a lack of understanding and respect.
- Adequate records had not been maintained in respect of those employed by the service.
- There were discrepancies in the accounts given by managers and a nurse regarding the management of mattress settings. We were also told that changes had been made to a mattress that had not been carried out.

Measures to assess, monitor and improve the quality and safety of the home had not been adequate. Accurate and complete records had not been kept. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were not actively involved in developing the services or consulted about changes that affected them. Several people mentioned the changes to the management team and staff but said they hadn't been told about the changes. One person explained, "We haven't been told what's going on. It has been very unsettling". A relative was surprised during discussion with inspectors in February 2022 that a manager who had been in the home in December 2021 had left. They had not been informed about changes in management.

● Two people told us they had been disturbed at night by building work after 8pm. Neither had been forewarned or consulted with about the potential disruption to their life, of works going on in their home.

Feedback had not been sought from people, or their representatives. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We also received feedback that the provider had told staff they could contact them directly with any concerns. This offer had been appreciated.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility, which is their legal responsibility to be open and honest with people when something goes wrong

● People, their relatives and staff spoke about the frequent changes to management and staff in recent months and the impact this had on the quality of care. One person said, "There's no management here now. It's like the Mary Celeste with no captain. All in all, it's pretty depressing here at the moment". A relative said, "They've had three or four managers in past months which is a worry… We do feel overall standards have dropped…"

● A staff member also reflected on the impact saying, "It is very stressful at the moment due to all the changes. So many managers in a short space and all have their own way of working – it's hard for staff to keep up." Staff acknowledged the impact of change. We received comments which included, "The past six months has really trying, and we are all quite exhausted." The staff team lacked leadership and direction at times. Staff told us they needed stability and consistency within the management team to get the service back on track.

● A decision had been made by managers to implement new care plans. These were being implemented at pace and there was evidence that they did not always reflect individual people's needs.

Working in partnership with others

● Whilst managers and the clinical lead were responsive during our inspection they did not always take effective action.

● We received feedback from the Dorset Quality Monitoring team that this reflected their experience.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not assessed to ensure person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care had not been sought within the framework of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to monitor and improve the safety and quality of care people received. Contemporaneous and accurate records had not been maintained for people or staff. The views of people and their representatives had not been sought about changes in the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always assessed, monitored safely and mitigated. Systems were not robust enough to demonstrate medicines were effectively managed. Infection prevention control measure were not robust.

The enforcement action we took:

We served a warning notice on 29 March 2022. The provider must be fully compliant with the regulation by 24 June 2022.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were deprived of their liberty without lawful authority.

The enforcement action we took:

We served a warning notice on 29 March 2022. The provider must be fully compliant with the regulation by 24 June 2022.