Whittington Care Limited

Whittington Care Home

Inspection report

40 Holland Road
Old Whittington
Chesterfield
Derbyshire
S41 9HF

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22 October 2021

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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
Whittington Care Home is a care home providing personal and nursing care to 39 people aged 65 and over at the time of the inspection. The service can support up to 48 people.

The home is set across two floors, each containing bedrooms and bathing facilities. The ground floor has two communal spaces and access to outside space.

People's experience of using this service and what we found
The service lacked provider and management oversight. There had been no audits for six months and therefore no actions taken in these auditable areas to drive improvement or reduce risks. The culture of the service was not in accordance with empowering people or encouraging independence. Maintenance in the home was not always completed to meet national regulations or to follow advice in relation to best practice.

There were not enough staff to support people's needs. Staffing was not always provided in line with the agreed rota, which reflected the tool used to show each persons needs. Staffing levels had not always been reviewed to consider changing needs or health impacts. Staff had not always received the required training to support their roles or people's needs; and staff had not received supervision as part of their development or support network.

Infection prevention and control was not always well managed to ensure people were protected from the risk of infections. Risks to people were not always assessed or any identified risks mitigated.

Safeguarding concerns were not always reported to local authorities to protect people from harm and identified safeguards had not been investigated or actions taken to reduce the risk of harm.

People were not always supported with their hydration or nutritional needs. People's weight had not been routinely recorded or action taken to ensure dietary needs were met. Medicines were not always managed safely in relation to the administration of medicines and the application of topical creams.

People's dignity had been compromised by the lack of staff and the culture of the home. Communication with relatives was poor and complaints had not been addressed.

Care plans were not up to date and did not contain individual details to ensure the care was person centred. There was no stimulation provided and people were not encouraged to make decisions on how they spent their day.

The provider worked in partnership with other professionals and referrals had been made appropriately. However, communication in relation to guidance or required health actions were not always shared with

care staff , or followed.

People were supported to have maximum choice and control of their lives and staff supported in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
This service was registered with us on 21 September 2020 and this is the first inspection.
The last rating for the service under the previous provider was Good, published on (14 December 2017). At this inspection we have found improvements were required and the rating has deteriorated to Inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, levels of care and provider oversight. A decision was made for us to inspect and examine those risks. We found evidence the provider needs to make improvements, please see the full inspection report.

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

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety, safeguarding, staffing and staff training, complaints, people's dignity and overarching governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. 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 six 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**

Whittington Care 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 Care Act 2014.

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

Inspection team
This inspection was completed by two inspectors, a nurse specialist and an Expert by Experience. A nurse specialist has nursing knowledge to review these areas of the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Whittington Care Home 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 service had a registered manager registered with the Care Quality Commission, however on day two of our inspection they left the service. The service has a nominated individual, and 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 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 spoke with local commissioners and health care professionals and used all of this information to plan our inspection.

During the inspection
We spoke with sixteen staff members including the registered manager, nurses, advance nurse practitioners, senior care workers, care workers, domestic, maintenance and the chef.
We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were also reviewed.

After the inspection
Our Expert by Experience contacted relatives and representatives of seven people using the service. We also received contact from three relatives through the CQC website. We continued to seek clarification from the provider to validate evidence found. We looked at training data and further quality assurance records. We requested policies and additional information from the provider.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management: Using medicines safely

- Risks were not always managed. Some people required pressure relief to maintain skin integrity on a two-hourly basis, however we found some people remained in the same position for over four hours. This meant regular relief was not always provided, placing people at risk.
- People's weight had not been completed routinely due to broken equipment. This meant any weight loss or gain was not monitored and placed some people at risk of not receiving the required levels of dietary support. We found two people had significant weight loss and no action had been taken.
- Medicine was not always managed safely. We found gaps in the recording of the medicine administration records. Some 'as required medicine' did not have a protocol to guide staff when the medicine should be administered. This placed people at increased risk of harm.
- Topical creams had been prescribed for people's skin, however there was no monitoring process in place to ensure these were being applied as required. We found creams which had not been dated on opening and other creams which were out of date, which could impact on the integrity of the cream.
- The provider had not made provision for the management of the monthly medicine cycle. We found boxes full of medicine in the clinical room and small lounge awaiting night staff to complete the changeover. No additional staff had been planned for this task, which meant night staff would be diverted from providing direct care. Some people were delayed from receiving their daily medicine because the stock had not been booked in.
- Fire safety records had not been maintained. We found five people living in the home did not have a personal emergency evacuation plan. Fifteen people who did have a plan no longer used the service and six plans reflected the incorrect room. This meant should there be a need to evacuate the service, some people may not be accounted for, or others have their needs met for a safe evacuation.

The provider had failed to ensure that people were protected from the 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.

The provider responded immediately during and after the inspection to update fire evacuation records and topical cream applications.

Staffing and recruitment

- There was not enough staff to meet people's needs. In the providers PIR you told us, 'There is an agreed annual staffing budget for the Home; however, we also use a dependency tool that indicates the level of care

and staff hours people will require to meet their needs.' We found the dependency tool had not been used effectively to reflect the needs of people and therefore the staffing levels required.
● On several occasions we found the staffing levels to be below those detailed on the staffing rota. This meant people's needs could not always be met and the overwhelming feeling from staff was reflected in these two statements, 'Concerned as people are not getting the care they need.' And 'People don't get their care, we are rushing them as we don't have the time.'
● Some staff were moved from their role to support in the kitchen, leaving other areas not covered by staff to maintain the hygiene of the home. Other non-care related roles, for example office staff and maintenance were redirected to support people during mealtimes. These staff had no training in these areas of how to support people safely, placing them at risk of choking.
● Relatives we spoke with also reflected their concerns. One relative said, "I did feel [name] was safe, but not recently due to staff shortages, they told us they have been left longer with no personal care until 1.00 pm, therefore I don't feel it is a safe environment due to lack of staff."
● The provider did not have a robust recruitment process. We reviewed three recruitment records and found they did not always contain employment history. The applications were still being completed on the previous providers documentation and no induction process was recorded or any required risk assessments completed. This meant we could not be assured the provider had taken all the required measures to ensure staff working with people were safe to do so.

Staffing levels were not sufficient to meet the needs of the people using the service, placing them at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. The provider reviewed the dependency tool and ensured the required level of staff were in place to meet people's level of need.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong
● People were not protected from the risk of harm. Not all the staff had received training in safeguarding and those we spoke with were not aware of all the areas which should be reported.
● We found some people had unexplained bruises, these had not been reported or any investigation completed to consider reduction of risks of these reoccurring.
● Some safeguards had been raised with the local authority. We found these had not been investigated. One relative raised concerns in relation to a safeguard that had been raised, stating there was limited communication or any outcome. They told us, "[Name] has had a couple of safeguarding incidents no answer from the staff as to how it happened, or actions taken." This meant lessons had not been learnt or shared or measures put in place to reduce the risk of possible harm.

The provider had failed to ensure that people were protected from the risk of harm. 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.

Preventing and controlling infection
● We were not assured about some of the provider's measures in place to reduce the risk of infections.
● The provider shared their COVID 19 policy, however it referenced it should be used in conjunction with the provider's infection prevention and control policy. This policy had not been updated since 2018.
● The COVID 19 policy had a step by step guide should the service have a COVID 19 outbreak. Step 8 of this guide references enhanced cleaning and the appropriate use of PPE. One staff member told us, "There has been no increase in domestic hours during COVID 19, just extra duties with touch points." We found that

during a COVID 19 outbreak, the cleaning had not been increased and some touch point areas were not consistently completed.

● During our inspection, we found staff were not always compliant with the wearing of face masks in accordance with the guidance or the providers policy. Risk assessments had not been completed for staff who were medically exempt from wearing face masks to consider how to reduce the risk of infection to people.

● We were assured that the provider was accessing testing for people using the service and staff.

● In accordance with guidance, the provider had facilitated visits.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
- Staff had not received the required training for their roles. New starters had not received any training or induction. Competencies had not been completed for any new staff who had previous care employment experience to consider their knowledge or skills.
- Several staff told us the only training they received was online, these courses use a computer and are completed individually following a programme. We reviewed the training matrix and found gaps in all areas of training for all staff.
- Staff had not received any supervision or probationary support meetings to guide their role or future training needs.

The provider had failed to ensure staff received appropriate support and training to enable them to carry out the duties they are employed to perform. This placed people at risk of harm. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People had limited choices how to spend their day and most remained in the communal space with no interaction.
- Evidence based guidance and best practice was not always in place when recording people's weights and daily care requirements.

Supporting people to eat and drink enough to maintain a balanced diet
- People were not always supported to receive the required hydration and nutritional support they required.
- We found the breakfast drifted into lunchtime with people missing out on midday refreshments. Some people required their fluid levels to be recorded, we found these records to either be incomplete or the fluid levels not totalled. This meant we could not be assured people received the required daily fluid intake.
- The information in the kitchen in relation to people's dietary needs was limited and not up to date. This placed people at risk of receiving the incorrect diet.
- Some people required thickener in their fluids to reduce the risk of choking. The thickener was prescribed

and should be used for the individual, it reflects the details of the thickening levels for that person. We found thickener being used generically in the lounge and in people's rooms, in both areas it was unsecured. Good practice recommends thickener should be stored away after use, when incorrectly used this can be a choke hazard.

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

● People were not always supported with their health and care needs. In the PIR you told us, 'We liaise daily as necessary with local GPs, district nurses and other community professionals.' We found there was a process in place and referrals had been made when identified. However, we were not assured that information provided was updated in the care plans and shared with staff to ensure current needs were being met.

● One relative told us the staff team were not following their relative's daily routine to manage their care. They said this had an impact on the individual's mood and their comfort levels.

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

● The environment was not always suitable to support people to orientate. The clock in the main communal space was of a design which made it difficult to see the correct time, meaning people could not relate to the time of day.

● There was no orientation board, or signage to support people living with dementia.

● The Home had communal spaces, however one was awaiting deep cleaning and a smaller lounge was out of use due to the monthly medication being placed in there. This meant there was limited spaces for people to use and impacted on some people having the required space or quieter environments they enjoyed.

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.

● People's level of capacity had , in most instances been assessed when required. We found capacity assessments had been completed and were decision specific. Following these best interest decisions had been recorded.

● Relatives we spoke with felt they had not always been consulted in relation to decision making and we found for people who had recently been admitted the assessments had not been completed in full.

● When required a DoLS referrals had been made an ongoing review of these was in place.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated with dignity and care. We observed staff did not respond to some people's needs.
- One person did not have access to their call bell because it was wedged down the side of their bed. This meant they had no way of attracting attention when they required support.
- We observed one person requesting support for the toilet and were told they had to wait as they were only using one toilet. No reason was given for the use of one toilet, other toilets were further away from the main communal space. The person became distressed and we intervened to ensure the person was taken swiftly to another toilet.
- Staff did not always have the time to give people compassionate support when needed. One relative shared their concerns, " There is a lack of communication, I booked a visit and when I got there [name] was still in bed and it took a while then to get them ready and they were rushed."
- Staff we spoke with reflected on people not receiving regular opportunities to receive a bath. One staff member said, "We do what we can with people. Things get missed, like bathing." Another staff member said, "We go home knowing we have not done enough. Priorities and things get missed." This meant people's care needs and choices were not respected.

We found evidence that people were not supported with their dignity. This placed people at risk of harm. This was a breach of regulation 10 (Dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not supported in their decision making or to receive care in a timely way.
- There were no opportunities for people to express how they wished to spend their day; we saw people sat in the communal spaces with no stimulation.
- Communication was raised as a concern from the relatives we spoke with. One relative told us, "[Name] recently went into hospital, it was [name] who informed us, not the home, I have often left messages regarding visiting and no one calls me back."

● Another relative said, "Communication is variable and woeful at times, [name] was supposed to have an identified worker to contact, but we have not heard who it is. The home doesn't always let us know if [name] has been to hospital or they don't inform us of the outcome of an incident."

● The contact numbers shared with us for relatives and representatives were not all correct. This meant we could not be assured contact would be made to the correct contact to share any concerns.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- Complaints were not being addressed and responded to in line with the providers policy. The policy states, 'One of the ways in which the Care Home can continue to improve its service is by listening and responding to the views of its residents and their relatives, and by responding positively to complaints, and by correcting mistakes.' We found this policy had not been followed.
- There was confusion in the response times by the provider. The policy states an initial response within two days and an overall response within 20 days. However, the complaints poster stated a response within three days and an overall response in 28 days. We found no responses had been completed in line with either of these details.
- We reviewed the complaints folder in the home and found there was no details of the policy or any records of any complaints received. Relatives had shared with us that they had made complaints or raised concerns, however there was no record of these. One relative said, "If you leave a message with a query, no one gets back to you, we have not felt happy for seven months now."
- One relative shared with us that they had contacted the home and the provider on four occasions and had not received a response to any of these contacts.

The provider had failed to ensure complaints were recorded and addressed to provide people with assurances or resolution. This was a breach of regulation 16 (Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always have a care plan which was reflective of their individual care needs. Care plans had not been updated to record professional guidance, a change in need or any personal details which could impact on a person's emotional state. For example, one person had lost their life partner, this had not been recorded. However, daily records recorded the person as upset and uncooperative. No reflection of their emotional needs over this early bereavement period had been considered.
- When people had behaviours, which challenged there was no guidance to consider any consistent approach to reduce their anxiety.
- Staff shared their concerns, one staff member said, "Care plans are not being updated or reviewed. When doing a continuing health care assessment, the information is not available."

● We identified care staff did not receive a handover. Staff told us this left them vulnerable to not having the information for people's needs and this had led to some near misses. One staff told us, "I was not told [name] required fluid thickener, I was about to give them a drink without it, but luckily someone stopped me." Another staff member told us, they took a call from a relative enquiring about [name] and if they had returned to the home from hospital. The staff member told us, "I had to run up to their room to see if they had returned, it's embarrassing."
● People were not provided with any stimulation. One relative reflected on the lack of activities, "I worry [name] are in their room all day and not taken to the communal areas which would be good psychologically, there are no real activities." We found the communal space to be uninviting, with no music or opportunities for activities, newspapers or positive interactions.

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.
● People were not supported with their communication needs. In the PIR the provider told us, 'We currently do not have any people who require alternative formats of communication; however, we would source these aids if required in the future'.
● We found several people who had limited verbal communication and would have benefited from aids to support their daily choices.
● Some people required glasses to support their day to day vision. We reviewed two people who should wear glasses daily. Neither of these people had their glasses on and when discussed with staff they were not aware they had glasses and the importance of these.

End of life care and support
● At the time of the inspection there was no one on end of life care. We reviewed some end of life care plans and found these covered the basic scope of need in this area.
● However, the plans could have reflected people's personal requirements to ensure people received care which was meaningful and fulfilled their last wishes.

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.

This is the first inspection for this newly registered service. This key question has been rated 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, Continuous learning and improving care.

- The service was not well managed and we found limited provider oversight. In the PIR the provider told us, 'Regular monthly audits are in place and actions are either addressed immediately or reported for an action plan to be created.' We found no regular audits were in place, the last recorded home audit was March 2021.
- Accidents and incidents had not been analysed. All these had been recorded on the providers system, however there was no detailed analysis to identify any trends or areas to prevent reoccurrence. We found some people had reoccurring skin tears, falls and infections which could have been mitigated by reviewing risk assessments and staff support.
- Maintenance and repairs were not completed leaving possible areas of risk. One area related to the doors within the home not being compliant with fire regulations. We asked the fire service to attend and they have advised on other areas which require addressing to meet the safety regulation standards.
- Repairs had not been completed in relation to advisory notes following electrical checks having been completed ,and some broken furniture still remained in use in people's rooms.
- The provider had not established any oversight of the home, in ensuring audits and improvements had been implemented to meet the regulations or standards. The registered manager had not received the required support through supervision or guidance to identify any learning or training needs in the providers systems or in meeting standards.
- Confidentially was not always followed in line with the provider's policy on use of mobile phones. We found personal mobile phones had been used to photograph people without their consent for the care plan records.
- The providers policies were not always up to date or recorded when reviews had been completed to meet new or updated guidance and best practice.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people

●The culture of the home had been impacted by the lack of staff and insufficient leadership. Relatives shared with us their concerns about the leadership and communication.

● One relative said, "You contact the home and they don't get back to you or respond to the concern. When I have eventually raised an issue, it has not been addressed."

● Staff were not always organised, or the work allocated to ensure all care and needs would be completed. We saw staff took breaks in groups, often leaving areas of the home unsupervised.

● Staff morale was poor, and staff felt they were not listened to and many shared their concerns with us. Some staff who had been in the service for a long time, reflected the lack of acknowledgement at their expertise. One staff member said, "After all these years they have not asked for my input, I don't feel I have a place here or know my role".

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

● People and staff were not supported to be part of the development of the service.

● There has been no surveys or engagement with relatives or representatives. Opportunities through virtual meetings or newsletters had not been taken to share information.

● Staff had not received regular support. There had been no staff surveys within the last 12 months. Meetings which used to be held for the head of department had stopped, which meant information was not being shared and could impact on aspects of care not being completed.

● Staff felt they were not listened to. Some staff had contacted senior managers raising concerns in relation to the staffing levels. These concerns were not addressed, and the staffing remained a concern until we completed the inspection.

Working in partnership with others

● Partnership working with health and social care professionals had been established. However, we could not be assured information guidance was followed or people's independence encouraged. For example, some peoples care plans detailed exercises and to encourage mobility with the use of a walking aid. We found staff used wheelchairs to move people from location to location and exercises had not been completed, this reduced their opportunities to increase their level of independence.

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 10 HSCA RA Regulations 2014 Dignity and respect The service did not always respect people's dignity and this may have an impact on the person feeling valued.

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 The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. The provider had not ensured the premises used by the service was safe. Risk to peoples health and well being were not always monitored or care maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had not been protected from harm and improper treatment People were not supported to ensure any safeguards were investigated and measures used to reduce the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not responded to complaints as required by the regulations.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not well led. There was no established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made. Risks had not been reviewed placing individuals and others at risk of harm. Experience of using the service had not been obtained from people. Communication with people using the service and those important to them had not been established to share how the home was being managed.

The enforcement action we took:

NOD urgent conditions for admission and reporting conditions.

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 There was not always sufficient levels of staff to respond to people's needs. The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs. Staffing levels had not been continuously reviewed to adapt to the changing needs of people. The provider had not ensured the staff received training at a relevant level to provide them with the skills to keep people safe at all times.

The enforcement action we took:

NOD urgent conditions to restrict admissions and reporting requirements around staffing and auditing.