Hawksyard Priory Nursing Home Limited

Hawksyard Priory 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 caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Hawksyard Priory Nursing Home is a nursing and residential home providing personal and nursing care to up to 106 people over three different floors. There is access to a church and gardens at the service. The service provides support to people with physical and emotional needs, some of whom are living with dementia. At the time of our inspection there were 61 people using the service.

People's experience of using this service and what we found
People were not supported in a safe way by staff who had clear guidance and knowledge around their needs and the associated risks. People were not supported in a safe way to receive their medicines. People were not supported in a well maintained environment. People involved in accidents and incidents were placed at prolonged risk of harm as action was not always taken to mitigate future risks. At times, people had to wait for support and their needs were not always met.

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. People were not always supported in line with their needs around eating and drinking. People and those important to them were not always involved in reviews around their care. People did not always have timely access to healthcare professionals.

People were not treated in a caring way by staff that promoted their dignity and respected their independence. People's preferences were not always included within their care plans. Quality assurance tools had failed to identify where improvements were required to people's care and support placing them at prolonged risk of receiving poor quality care. People's feedback was not acted on in a timely way.

We have made a recommendation around the recruitment process and deployment of staff.

People felt able to complain and relatives felt staff knew people.

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 requires improvement (published 09 March 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of risk and leadership at the service. A decision was made for us to inspect and examine those risks.

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.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hawksyard Priory 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 people's safe care and treatment, dignity, capacity and consent, the upkeep and safety of the environment, supporting people safely with their nutrition and hydration and the leadership and oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Hawksyard Priory 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.

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 five inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Hawksyard Priory Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Hawksyard Priory Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with nine people and 12 relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed sixteen people's care records and multiple medicines records. We also spoke to 24 members of staff including the registered manager, consultant, receptionist, clinical lead, nurses, senior care staff, care assistants and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of 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.

At our last inspection we rated this key question requires improvement. 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
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and give staff clear guidance to mitigate these risks. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- At our previous inspection we found staff did not have access to information about how to support people when they expressed their emotional distress. At this inspection we found the provider had not taken action to address this. People's care plans did not contain sufficient information for staff to be able to support people when they were distressed and were not updated after incidents occurred. This placed people and staff at risk of harm.
- One person had two episodes of choking after taking food from another person's bedroom and plate. However, these incidents were not included in this person's risk assessments. We observed the person was left unsupervised by staff whilst eating their lunch around other people who had food that could have placed them at risk of a further choking episode.
- Following a series of falls, a person had been placed on one to one support from staff. However, the staff member supporting this person was not aware of why they were supporting this person on a one to one basis. This placed them at continued risk of harm.
- Where people were at risk of skin damage, records showed people had not always been repositioned at the frequency identified in their care plans. For example, one person's care plan stated staff should support them to reposition every two hours. However, we found intervals of up to 23 hours and 50 minutes where staff had not recorded supporting this person to relieve the pressure on their skin. This placed the person at risk of further skin damage.
- People with specific healthcare needs did not consistently receive support with these in line with their care plans. For example, one person had epilepsy and staff did not follow this person's care plan and call emergency services following them having seizures on two occasions. This could have placed the person at risk of harm.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not managed safely as people had not always received their medicines as prescribed. For example, one person had not been supported with medicines for seven days as they were out of stock. No action had been taken prior to the person running out of medicines to ensure they would not miss a prescribed dose. This placed the person at risk of harm.
● There were multiple missed signatures on people's medicines records. We checked with staff whether these had been reported to the registered manager however this had not consistently been the case. As stock counts were not always completed on people's medicines, we could not check whether people had received their medicines as prescribed or whether this was a recording issue. This placed people at risk of harm.
● People were administered medicines that had passed their labelled expiry date. For example, records confirmed staff had administered two medicines to a person on the day a medicine had expired and the following day. This meant the efficacy of the medicine may have been impaired, putting the person at risk of harm.
● There were not always records in place for staff to record supporting people with their topical creams. This meant the provider could not be sure whether people were receiving these as prescribed. This placed people at risk of skin damage.
● Where people were prescribed medicines on an 'as required' basis there were not records in place giving staff clear guidance on how or when these should be given. This was a concern as not all people at the service were able to verbally communicate their needs and a high proportion of agency staff were used. This placed people at risk of harm of not receiving their 'as required' medicines as prescribed.

Systems had not been established to ensure medicines were stored, recorded and administered safely. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● We received mixed feedback about people's safety. One relative told us, "Yes I think [they] are safe." Another relative told us, "From what [my relative] has told me there are a few other residents who make them feel unsafe."
● Staff understood the different types of abuse and stated they would raise concerns with the management team should they arise. However, staff were not always clear about where to report concerns should they the management team not be available. This meant there may be a delay in incidents being reported and action being taken to keep people safe.
● Where concerns had been raised with the management team, these were sent to the local safeguarding team for further investigation and review.

Staffing and recruitment
● At the last inspection we received mixed feedback about staffing levels at the home. At this inspection we found staff were not always deployed effectively and there was a high proportion of agency staff. This meant staff did not always have clear leadership on where they should be and who they should be supporting and agency staff did not always know people and their risks well. For example, where people required assistance or supervision at mealtimes they did not always receive this. We observed one person waiting over twenty minutes for support with their meal, by which point the meal was cold.
● Relatives told us staff were rushed. One person told us, "[They are] sometimes short staffed." One relative told us, "I think there isn't enough, if you press the alarm bell, it takes staff a long time to come."
● The registered manager used a dependency tool to determine how many staff were required to meet people's needs. However, without effective leadership staff were not always able to meet people's needs in a timely way. Staff told us, " [The management] need to look at people's needs. Sometimes we have to make

[people] wait longer than we should." This placed people at risk of harm.

We recommend the provider review staff deployment alongside people's dependency needs to ensure there are not delays in people's needs being met.

● Staff recruitment files contained gaps in information and the provider's checklist had not always been completed. For example, one file we reviewed did not contain copies of their photo identification or complete evidence of the person's qualifications or previous employment history.

We recommend the provider review staff recruitment files to ensure these contain complete information to ensure staff are consistently recruited safely.

● Records showed staff had undergone criminal records checks by the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● There were multiple areas of the service in require of update and repair as well as soiled and thread bare furniture and bedding. This placed people at an increased risk of cross contamination as these areas could not be or were not effectively cleaned.

● 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 assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● People were supported to have visitors as per their preferences without limitation through a booking service.

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

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

- People were not supported to eat and drink in line with their needs placing them at significant risk of harm. We saw people being given foods that were not in line with their assessed dietary needs. For example, where people were assessed as requiring a soft and bite size diet, we observed they received hard foods which had not been cut up. This placed them at risk of choking.
- People at high risk of choking who required staff support, encouragement and observation at mealtimes did not always receive this. For example, we observed occasions where staff had failed to offer people support to eat; this meant meals were left uneaten. This placed people at risk of weight loss and malnutrition.
- Records supported this as on review of people's fluid charts there were multiple people who had no fluid recorded or amounts below their recommended fluid balance for prolonged periods. This placed people at increased risk of dehydration.
- People who took their food and fluids via a percutaneous endoscopic gastrostomy (PEG) did not always receive these as assessed and required. A PEG is a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. This helps people with eating and drinking. For example, one person with a PEG had no feeds recorded on 11 occasions, one of these was for four consecutive days with three further occasions for two consecutive days. This placed the person at significant risk of malnutrition and harm.
- Staff failed to offer people choice around their meals and drinks and support them to understand what they were eating. For example, staff did not always offer people a choice of drinks and did not explain to people living with dementia what their meals were.

Systems had not been established to ensure people were consistently supported to receive adequate diet and fluids in line with their nutrition and hydration needs. This placed people at risk of significant harm. This was a breach of regulation 14 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 , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People did not always have capacity assessments or best interests decisions completed where there were restrictions on their liberty. For example, where people received one to one staff support due to risk, their capacity had not always been considered prior to making decisions around their care. This meant people were being deprived of their liberty without the proper authorisation.
● People also did not always have capacity assessments or best interests decisions completed where they were given their medicines covertly. This meant people's rights under the MCA had not been upheld and people and those important to them had not been consulted before people were given their medicines without their knowledge.
● People being supported on a one to one basis by staff members did not always have capacity assessments or best interest decisions completed to reflect these restrictions on their care and supervision.

Systems had not been established to ensure people received care in line with the MCA and DoLs. This placed people at risk of significant harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had some knowledge of MCA however this could be improved. One staff member told us, "We do e-learning to see if need to do things in best interests if people don't have capacity." Whereas another staff member told us, "I have not had to do these."

Adapting service, design, decoration to meet people's needs
● The environment of the home required upkeep and repair throughout. For example, we saw broken windows, damaged flooring and plaster, cracked tiles and loose wiring. Whilst the provider told us they had received quotes to make improvements to the service, this was a concern from our previous inspection in September 2021 and improvements had not been made. These were not conducive to people's wellbeing and placed people at risk of harm.
● Where people were living with dementia, the environment did not support them to orientate themselves within the service. For example, there was not adequate signage for people to access toilets independently or to identify their bedrooms.

Systems had not been established to assess, monitor and mitigate risks in relation to the environment. This placed people at risk of harm. This was a breach of regulation 15 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
● At our last inspection we raised concerns that people's care plans did not always reflect their needs. At this inspection we found improvements had not been made and further concerns were identified.
● People's needs were assessed prior to the start of their care. However, these were not always updated to reflect changes in their needs or professional advice given. For example, following a serious incident involving the police and local safeguarding team a person was supported on a one to one basis by staff . Whilst they were receiving this level of care, this was not reflected within their care plan and the staff supporting them on a one to one basis was not aware of this serious incident.
● People's involvement in the planning and review of their care was not reflected within their care

documents and relatives raised concerns that they had not always been involved in people's care following their initial assessment. One relative told us, "Initially I was involved, [they] have been there since 2019. I've not been involved since then." Another relative told us, "I have never seen a care plan or been involved in reviews."

● People had oral health care plans which gave staff guidance around how to support people to maintain their oral health care needs.

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 to access healthcare professionals when they needed them. For example, there was delays in people's weight loss being referred to professionals for additional support.

● People's hydration risks were not always identified by staff which resulted in external professional support not being accessed to reduce future risk. This placed people at risk of harm.

Staff support: induction, training, skills and experience

● Relatives gave us mixed feedback on staff knowledge. One relative told us, "Some of the staff know [persons' name] needs and risks, but some of the staff do not.

● Staff received an induction and training to support them in their role. One staff member told us, "We do all the basic training and the rest in e-learning."

● Newly recruited staff told us they completed an induction and training.

● Staff told us they had access to supervisions and appraisals.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence

- At our last inspection the provider was in breach of Regulation 10 (dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found people were not always listened to and treated in a way which promoted their dignity. At this inspection we found improvements had not been made and the provider remained in breach of this regulation.
- People were not treated in a dignified and respectful way by staff. We observed people being spoken to in a derogatory way. For example, one staff member told a person living with dementia to 'be a good boy' whilst supporting them to eat.'
- A person was observed to be wearing ill fitting trousers exposing their stomach. Staff had to be prompted by the inspection team to support this person to maintain their dignity.
- People were supported by staff to eat meals which were not warm enough. We observed one person telling staff their meal, 'could be warmer'. The staff member supporting them did not acknowledge this comment and continued to feed the person until prompted by the registered manager to reheat the meal.
- People were wearing stained clothing, did not always look well kempt and were not supported to change out of their nightwear. One person told us they would like to get dressed sometimes out of their nightwear but staff never asked them.
- Staff failed to show a person living with dementia where their cutlery was, resulting in them eating a pureed meal with their hands until they located their cutlery independently. This did not promote their independence.

Staff did not consistently support, promote and maintain people's dignity. This did not champion people and placed them at risk of a deterioration in their wellbeing. This was a continued breach of regulation 10 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 encouraged to make choices about how they were supported. We observed care and support being done to and for people as opposed to involving people. One relative told us, "I am not really seeing a massive amount of choice for her, now they choose her clothes for her, she doesn't choose clothes. I don't know anymore."

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

- People were not treated in a caring way. For example, we saw an agency staff member call a person a 'the fat lady' during our inspection.

● One person made numerous requests to go outside to staff throughout the two days of our inspection. However, the person was not supported by staff to achieve this.

● Whilst staff were not always aware of people's care needs relatives reported they knew most people well. One relative told us, "Yes they seem to know her quite personally, they sound like they have a personal rapport with her."

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

●There was no evidence people and their relatives were actively involved in reviews of their care . One relative told us, "I have never seen a care plan or been involved in reviews. There was an initial review when she went to live there. That was it."

● People's preferences were not always included in their care plans. For example, some people's care plans contained limited information about their food preferences and no further information about other aspects of their care and support.

● People being supported on a one to one basis did not have active engagement with the staff supporting them and we observed long periods of time where staff were sat in silence observing people as opposed to building relationships with people to better understand their likes and dislikes.

End of life care and support

● People and those important to them, had not always been consulted around choices they would like to make in their end-of-life care. This placed people at risk of not receiving support at the end of their lives in line with preferences. One relative told us, "No, its not been mentioned."

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

● People were not supported to access a variety of activities in line with their preferences. We saw limited examples of activities which did not include people who were nursed in their bedrooms. One relative told us, "I wish there were more activities."

● People had limited, task based communication with staff. We saw people living with dementia had limited engagement and choice around how to spend their day. This resulted in many people spending prolonged periods of time in their rooms or sitting in lounge areas with no engagement.

● Some people were supported to access outside areas of the home and to complete craft activities.

Meeting people's communication needs

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

● People had communication plans in place, however staff did not always have sufficient knowledge and understanding of these to consistently meet people's needs. For example, one person with a learning

disability was frequently ignored when attempting to communicate their needs nonverbally to staff. This resulted in the person becoming distressed.
● We saw examples of staff speaking over people or walking past people attempting to communicate their needs. This may have impacted on people's wellbeing.
● Relatives told us they saw positive examples of staff communicating with people. One relative told us, "I think that [staff] have a conversation with [people] and there is an attempt to chat to [my relative]."
● The provider told us people could access information in a variety of different formats including different languages where this was required.

Improving care quality in response to complaints or concerns
● People and those important to them felt able to complain. One relative told us, "I could complain to the lady at reception and the manager, they always take on anything and take action and put in place anything."
● Where complaints had been made these had been responded to by the registered manager and action taken in response to concerns.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

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

- At our last inspection, systems were either not in place or robust enough to identify issues and make improvements and there was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the service continued to be in breach of this regulation. The provider has been in breach of this regulation for the last six consecutive inspections. This was the tenth consecutive inspection where they had failed to achieve a rating of good.
- At our previous inspection we found audits had not identified areas for improvements, or where they had, actions had not always been taken to make the changes. This was a continued concern at this inspection. For example, audits on fire safety had failed to identify and act on concerns raised weekly by the maintenance team around fire doors since September 2021.
- At our previous inspection we found care plan audits were ineffective in identifying gaps in information for staff to support people when they were anxious or distressed. This was a continued concern at this inspection and meant people were at risk of harm or unsafe care.
- At our previous inspection we found wound care audits had failed to identify the concerns we found. At this inspection we found this was a continued concern and audits had failed to identify where people had wounds not included within their care plans and where they were not receiving support with their skin integrity as they required. This placed people at prolonged risk of significant harm.
- At our last inspection we found audits on care plans had failed to identify where these did not contain accurate and up to date information about people's needs. This was a continued concern at this inspection and we saw care plans contained conflicting information about people's mobility needs and were not always updated following significant incidents. This placed people at significant risk of prolonged harm.
- Audits had failed to identify and take action in regard to concerns we found around the mealtime experience and people not having the correct meals in line with their needs, choice around drinks and sufficient support. Reviews on people's weight loss had also not analysed potential reasons for this and taken action to mitigate future risk.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Whilst the registered manager understood their legal responsibilities in relation to the duty of candour,

they had failed to ensure they were aware of all accidents, incidents and near misses at the service so they could ensure they were consistently meeting this. For example, medicines errors were not identified through audit processes or shared by staff with the registered manager.

Working in partnership with others

● The service worked with other agencies to inform people's care and support. However, we saw professional advice was not always acted on. For example, where people had been assessed by speech and language therapists for specific diets, we found they were not always receiving these. This placed people at risk of harm.

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

● Whilst relatives and staff were sent surveys for their feedback, we found surveys completed in March 2022 had not been analysed and no action had been taken to address concerns around staff training and the environment; the management team and staffing. This meant the provider failed to ensure feedback was adequately listened to and timely action was taken to address any concerns.

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

● People and their relatives were not always aware of who the registered manager was. One relative told us, "I'm not sure who manager is." However, where they were aware of them relatives gave positive feedback about the registered manager's role in the home. One relative told us, "Yes I know [the registered manager], they are approachable."

● Staff gave positive feedback about the registered manager. One staff member told us, "I am confident can chat to [the registered manager". Other staff shared this view that the registered manager was approachable

● Relatives shared there were concerns around communication from the registered manager and management team. One relative told us, "There's always a feeling of them not communicating properly and not phoning back when they say they will."

● Poor communication was a theme throughout our inspection which did not promote good outcomes for people. For example, accidents were not always reported to the registered manager for their review to ensure action could be taken in a timely way to keep people safe.

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 11 HSCA RA Regulations 2014 Need for consent People did not always receive care in line with the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were not supported in a well maintained and safe environment.