Ranc Care Homes Limited

Brentwood Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Brentwood Care Centre accommodates up to 112 people who require nursing and personal care. Care is provided over three floors. The Balmoral unit accommodates people with nursing needs, the Windsor unit specialises in providing care for people with dementia and the Buckingham unit accommodates people with personal care needs. There were 57 people using the service when we inspected.

People's experience of using this service and what we found
The repeated changes of managers and staff turnover impacted negatively on the quality of life of the people at the service. A family member told us, "I have been coming here for a year and this is the third manager, I wonder what the underlying problems are?" People and families told us things were getting better with the recent arrival of the new manager, but we were concerned that the provider had a history of failing to sustain improvements.

Checks on the quality of the care and accommodation had not picked up all the concerns we found during our inspection. Where the provider had picked up concerns, measures were still being put in place and had not yet improved the service consistently. The manager had introduced new measures to learn lessons from mistakes, however further time was needed to ensure these made a difference to the care people received.

Lack of oversight meant people were not protected from risk of harm. Staff did not always administer medicines safely to people in line with their prescription. Measures to reduce the spread of infection were not adequate. Staff did not have the required skills to meet people's nutritional needs, in particular risks from choking were not minimised. The provider told us they were appointing more senior staff to improve coordination and drive improvements at the service.

There were enough safely recruited staff to respond to emergencies, however staff were not always deployed effectively. This particularly affected people's wellbeing as activity coordinators were drawn into care work. There was a reliance on agency staff. People and families told us they did not always receive good care from agency staff. Coordination and monitoring of agency staff was improving but this was still an ongoing concern.

There had been an increase in safeguarding alerts since our last inspection. The new manager had started to address this and was working well with the local authority to investigate and resolve the concerns.

The manager was supporting staff to develop their skills by improving staff attendance at training and supervision meetings. The provider had invested in enhancing dementia support at the service. Adaptations and decor reflected best practice and staff skills were being developed so they could better support people with dementia.

The manager was encouraging improvements to people's dining experience. Staff worked with external

professionals to meet people's health and social care needs.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However; the policies and systems in the service did not always ensure this practice was consistent and based on people's most up-to-date needs.

People were not always confident they would be supported by caring staff. Whilst some staff were compassionate and knew people well, people were not always supported in a respectful manner. People and families told us they became anxious when agency staff supported them or when staff were not available to meet their needs.

Staff carried out assessments of people needs and developed person centred care plans. Reviews of people's care took place; however, care plans did not always have consistent information about people's current needs.

There was a variety of activities on offer throughout the week, and staff had promoted positive links with the local community. However, people who were cared for in bed or who required support to leave their bedrooms did not always receive enough stimulation or encouragement to develop their interests or take part in activities and meals.

People, families and staff felt able to speak out and their complaints were responded to. There were regular meetings with senior staff where they felt they would be listened to. However, the rapid change in management meant the response they received was not always consistent and actions were not always followed up.

People received support when they required end of life care. Care plans lacked detail and were not always person-centred. We made a recommendation around best practice in this area.

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

Rating at last inspection
The last rating for this service was requires improvement (published 10 August 2018). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

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

Enforcement
We have identified breaches in relation to inconsistent management and oversight resulting in poor administration of medicines, management of choking risks and infection control. Please see the action we have told the provider to take at the end of this report.

We set up a meeting with the provider after the publication of the draft inspection report, to discuss any lessons learnt from the past which could help the provider sustain the current improvements and action plans.

Follow up
We will meet with the provider following this report being published 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Brentwood Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out on 24 and 29 July 2019. The inspection was carried out by two inspectors, a specialist pharmacist advisor and two experts by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two of the inspection was carried out by two inspectors.

Service and service type
Brentwood Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as 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 new manager who was not yet registered with the Care Quality Commission. This means that until the manager becomes registered the provider is solely legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included safeguarding alerts and statutory notifications, which related to the service. Statutory notifications include information about important events, which the provider is required to send us by law. We used the information the provider sent us in the provider information return, which had been completed by the previous registered manager. 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. We used all of this information to plan our inspection.

During the inspection
We focused on speaking with people who lived at the service and observing how they were cared for. Where people at the service had complex needs, and were not able verbally to talk with us, or chose not to, we used observation to gather evidence of people's experiences of the service. We spoke with 14 people and nine relatives.

We spoke with the new manager, the deputy who was also the clinical lead, three nurses, eight care staff, senior care staff, one activity coordinator, chef, and one maintenance staff member. We spoke with one visiting professionals. We also met with the providers chief operating officer, quality officer and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We also looked at a range of documents relating to the management of the service, including staff files and a range of quality audits.

After the inspection
We received additional information from the provider as requested. We had contact with three health and social care professionals who were involved in the care of the people at the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
• People did not always receive their medicines safely.
• We were concerned that the poor oversight of the Balmoral nursing unit and the Buckingham unit placed people at risk. The concerns outlined below refer mainly to these two units.
• Staff did not always give people medicines at the correct times, as prescribed. On the first day of our inspection a member of staff failed to administer time-specific medicines for Parkinson's in line with a person's prescription. Poorly timed administration of Parkinson's medicine places people at risk of deteriorating health. Staff did not consistently space out the administration of other medicines, as prescribed.
• We observed a member of staff record that people had taken their medicines when the tablets were still in pots on a trolley. There was then a delay in administering the medicines while another member of staff sorted out drinks to take with the tablets. This meant the times the member of staff had recorded on the medicine records were wrong. This increased the risk of medicine errors and impacted people who required medicine to be given at a specific time.
• Medicine records were not always accurate. Senior staff did not consistently act where the records indicated possible medicine errors. For example, in one unit, three people has been administered antibiotics beyond the instructions on the prescription, and this had not been picked up through the medicine audits.
• Staff did not ensure medicines were stored safely. We observed the keys for the medicines room on the ground floor had been left unattended by a staff member. As well as the people living on the unit, risk was higher as this was a particularly busy day with external contractors decorating close by and regular visitors. Elsewhere in the service medicines were locked away safely.
• There had been a medicine audit by the provider in May 2019 and external health professionals had reviewed the management of medicines June 2019. These audits had highlighted similar issues which we found on the day of our inspection, such as medicines not given as prescribed. We were concerned the provider had not acted promptly to minimise the risks to people from poor medicine administration.
• After the first day of our inspection the manager reviewed all people with time specific medicines and put measures in place to ensure they received their medicine on time. They also put in place a detailed action plan addressing our concerns.
• We observed some positive practice, in particular in the Windsor unit, where the clinical lead had already picked up the concerns we found and was taking action to improve safety.

Assessing risk, safety monitoring and management
• The provider had failed to ensure the chef had the necessary skills to meet people's specialist nutritional needs. Care staff told the chef about any individual requirements such as people who were diabetic or needed soft diets. We observed people requiring soft diets were given the inside filling of a pie. The chef did not use guidance from specialist professionals to ensure the food was at the correct consistency to minimise the risk of choking. We raised our concerns with the manager who took immediate action.
• Staff carried out risk assessments for each person, for example of how to support people to move safely.
• Some areas of risk were being managed well. For example, we reviewed the care of people at risk of pressure sores and found staff were providing the necessary support to minimise this risk, including referrals to specialist health professionals.
• A few weeks before our inspection there had been a flood in one of the units. Some people had to be moved to another unit. All the people, family and staff we spoke with told us the provider and staff team had responded well to the emergency to ensure people were safe and their needs were met.

Preventing and controlling infection
• People were not protected from the spread of infection. We observed a nursing staff handle tablets directly without gloves when administering medicine. We also saw another member of staff hand out biscuits without gloves or tongs.
• We were able to enter an unlocked sluice room which had bags containing clinical waste and used incontinence pads on the floor. A sluice room is where used disposables such as incontinence pads are dealt with, and reusable products are cleaned and disinfected. The manager told us this room was not in use, however we were concerned it was left unlocked and could be accessed by people and families. It also contained boxes with confidential care records.
• We saw a walking frame covered in dried food and an open basket with food residue in one of the bathrooms. This was not removed promptly, which posed a health and infection control issue hazard, especially given the bathroom was in the unit accommodating people with dementia.
• There was a lack of regular and structured daily checks, which would have highlighted issues requiring immediate action. People and families told us the service was generally clean, but there was a lack of attention to detail and when concerns were not acted on in a timely manner. A relative told us, "I clean [Person's] bathroom to make sure it's done properly."

The provider had not ensured adequate systems were in place to protect people from the risk of choking, poor administration of medicine and spread of infection. This placed people at risk of harm. These findings demonstrate a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• Lessons learned folder had recently been set up in each unit. One example was the lessons learnt following an incident when a person was being transported in a wheelchair in a minibus.
• The manager told us they wanted all staff to have access to this information. This was a good practice, though further time was needed to measure how well the new measure worked.

Systems and processes to safeguard people from the risk of abuse
• There had been an increased number of alerts to the local authority about people's safety since our last inspection. The new manager had worked well and openly with the investigating officers since their arrival to resolve concerns.
• On the first day of our inspection we were able to enter the building and begin our inspection with minimal challenge from the senior agency staff on the ground floor. This placed people at risk of abuse and was not respectful as many people were receiving personal care at that time. We fed back to the manager our

concerns who agreed to address this.
• Staff knew what to do if they were concerned about people's safety.

Staffing and recruitment
• People and their families told us staff responded well to buzzers. A person told us, "I don't often ring the bell but they're usually pretty good." Our observations confirmed staff responded promptly when alerted to an emergency.
• People told us they often had to wait once their buzzer had been answered so the staff could attend to a person who needed them more. A person described an incident when they needed support with personal care and four members of staff separately came to turn their buzzer off but did not attend to their personal needs. This incident had a negative impact on the person's wellbeing and dignity.
• The service used a tool to calculate staffing, however the occupied bedrooms were spread across different corridors making deploying staff a challenge.
• The service was highly dependent on agency nurses. People told us this made them feel less safe and our findings confirmed the lack of permanent nursing staff affected safety and the quality of care at the service. The lack of permanent nurses put significant pressure on the clinical lead who was a qualified nurse.
• At our last inspection we found staff were recruited safely. The manager showed us a recent audit by the local authority which confirmed recruitment systems continued to work safely.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care plans were being revised and improved. This included ensuring they were more person centred and reflected the current needs of the person.
• Since our last inspection, the provider had worked with a university to enhance their dementia service, including designing a specialist dementia course and consulting on best practice.
• The provider had purchased a 'Toverfatel' table, an interactive projector which is used to stimulate and engage people with dementia and other needs. We did not see this used during the two days we visited the service. Staff told us it was used occasionally but limited by staff availability.
• We observed limited examples of best practice in dementia care during our visit to the service. A relative told us, "Staff on Windsor (the dementia unit) are good but not trained to support dementia fully" and described how this impacted on their family member.
• The provider had demonstrated commitment to ensure staff developed their skills. Further time was needed to embed learning and good practice throughout the service.

Staff support: induction, training, skills and experience
• People told us agency staff were not as skilled as permanent staff. A person told us, "The other day I had an (agency nurse) who didn't know how to hoist me." Our observations during our visit confirmed this difference in skill level.
• The manager had plans in place to address the skill level of agency staff and recruit more permanent staff. We also discussed with the manager their plans to improve the daily monitoring of all staff, but in particular agency staff. The manager told us they were employing additional senior staff who would ensure care was provided to the required level.
• Staff received training and had individual supervision meetings to ensure they had the skills and were supported to meet people's needs. The high turnover of senior and care staff meant this had not always been consistent, however the manager was improving attendance at training and supervision.

Supporting people to eat and drink enough to maintain a balanced diet
• The provider had not ensured that the chefs preparing food for people had the necessary skills to meet people's individual needs, as outlined in the safe section of this report.
• We spoke with the chef during our inspection and found them to be committed to the people at the service and enthusiastic about their role. People were offered a choice of meals. A person told us, "The apple

crumble is delicious, and I had a whole one to myself because I told the cook I loved it so much."
• The manager told us they had been focusing on improving the meal time experience and we observed some good practice, particularly in the Windsor unit. People had a choice of meals and staff spoke individually to each person and tried to make the atmosphere pleasant.
• In the nursing unit, very few people came to the dining room for meals and the atmosphere was not as agreeable. Two people told us they decided to eat in their rooms as they felt it was too much work for staff to support them to go to the dining room. Both people told us they would have gone to the dining room, if encouraged.
• It was very hot on the first day of visit and we observed staff were attentive, encouraging people to drink.

Adapting service, design, decoration to meet people's needs
• New adaptations and décor reflected the improved knowledge in supporting people with dementia. For example, some of the toilets had distinctly coloured toilet seats, to meet the needs of people with dementia. A corridor had been decorated using this best practice guidance, with items to promote memory and offer stimulation.
• Whilst the rest of the service was well decorated, some rooms, such as bathrooms, were cluttered and did not enhance people's quality of life. The lack of oversight and effective audits had not picked up issues which would be easy to resolve. The manager told us they were appointing a new housekeeper to address these practical concerns.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Care plans detailed people's health needs, but this information was not always holistic and did not give care staff sufficient guidance. For example, a person's care plan had general information on diabetes but did not include advice on monitoring sight or foot care, which is essential for maintaining the health of people with diabetes.
• Staff completed records to monitor people's health but did not always analyse the figures effectively, for example when people lost weight or did not drink enough. The manager was improving the oversight of people's health and had set up a chart to centrally monitor weights.
• During our visit, health professionals, such as paramedics, supported people at the service and we observed staff worked well with them to meet people's needs.

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.

• Staff asked people for their consent before any care was given and involved them in decisions about their care. A person told us that when staff supported them with a hoist, "They ask permission before they help

me." People or their representatives had signed forms to consent to care.
• Senior staff had carried out assessments of people's capacity and had requested authorisation from the relevant authorities when restricting people of their freedom, for example where locks prevented a person from leaving the service.
• Information about capacity was not always consistent throughout people's care needs. This was being reviewed as part of the overall review of care plans.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• People being cared for in bed were at risk of being lonely. This is discussed further in the responsive section of this report.
• Many staff were caring and focused on the person they were supporting, a person told us, "Carers hoist me gently and they give me confidence to let them do it." More established staff we spoke with knew people well and were committed to their care. We observed when a person fell staff supported them with compassion whilst they were waiting for the paramedics to arrive.
• However, support was not consistently caring, in particular, when people were cared for by agency staff or if there were not enough staff on duty. A person told us, "I find the staff are focused on what they have to do. I've even said, 'Are you happy, you never seem to speak. This is my home - it wouldn't take much for you to say, 'How are you?'"
• Care plans highlighted people's varied needs and promoted people's diverse needs. However, this was not applied effectively across the service in a holistic way. In one of the dining room a member of staff used the same equipment to check the temperature of the vegetarian and meat pies. This was not in line with the practice in the rest of the service and showed a lack of understanding and respect of people who were vegetarian.

Supporting people to express their views and be involved in making decisions about their care
• People and families told us they felt comfortable expressing their views. We saw records of involvement and discussion with people about their care.
• The lack of consistency in staff and management meant people felt they had to keep repeating themselves. A person told us, "I have tea in my beaker and quite often it is not stirred, all the sugar is at the bottom, I have told them." A relative told us how they had described to staff the best way to motivate their family member, but not all staff followed their advice.

Respecting and promoting people's privacy, dignity and independence
• People told us some staff did not promote their privacy. A person said, "It would make a difference if all of the staff said good morning. Some knock (before entering a bedroom) and some don't."
• Concerns discussed in the other sections of this report impacted on people's dignity. In particular, people told us they did not always feel staff supported them with the personal care needs. For example, a person told us they became anxious over personal care because they often had to wait for two members of staff to

be available to hoist them. Other people described how they did not feel their personal hygiene was maintained in a dignified manner.

• A relative told us, "I have to ask for my family member to have a bath and shower." They said, "I've got a relationship with staff and there's a lot of banter. Of course, it all benefits my family member and I feel the staff do give them attention because of this." The relative told us they were concerned for the people who did not have anyone to speak on their behalf.

• We observed positive practice where staff respected people's dignity. For instance, a staff member put up a screen when a person fell, to preserve their dignity and staff stepped in when they noticed a person had forgotten to close the door to the toilet.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question deteriorated to requires improvement.

This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The provider told us there were five activity coordinators, however we found people we not always supported to develop their interests and were at risk of being lonely and bored.
• Senior staff told us people being cared for in bed received individual 1:1 time. Staff told us they did not have the time to do this and our observations confirmed this. Activity coordinators were frequently drawn into providing care, such as accompanying people to appointments and providing continuity when agency staff were used. A family member told us, "Some days they have two agency staff on this unit. They don't have a clue about the resident's needs, they would be lost without the activity people." We discussed this with the manager who told us activity coordinators did support people at meals to enhance the dining experience, however they only accompanied people to appointments in exceptional circumstances.
• People who were cared for in bed described the impact on their quality of life. One person said, "The activity co-ordinators do this 1:1 but it's actually just handing over the activity sheet, and I can't do those things (planned activities). They all know that but are they listening? I just read so of course I'm bored lying here."
• People told us they wanted to get out of bed and join in the activities but admitted they needed encouragement to do so. One person told us, "I would get out more if they 'pushed me' but there's just not enough staff to have those conversations and I expect it's easier if I am prepared to stay in bed."
• We discussed this feedback with the manager who told us this was being addressed through the reduction in agency staff and the appointment of new staff to the service, this is discussed further in the well-led section of the report.
• People who were more independent had greater access to activities and communal areas such as the accessible gardens. We observed well attended activities in some units and received positive feedback in these instances. A person said, "I've joined in the quiz and it was interesting having the local children visiting yesterday making marks on my face and nose! I also do bingo and they come and remind me it's on." The service had developed close links with a local radio station which people enjoyed.
• Relatives told us staff communicated with them well, for example contacting them to let them know their family member had fallen.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans were person centred and where staff knew people well they provided personalised care, such as ensuring a person had a bath with their preferred bubble bath.

• Care was reviewed regularly, but care records did not always consistently show the most up-to-date care information throughout. For instance, one person's care plan stated they used a frame, although other information and our observations showed they were being cared for in bed.
• People did not always receive their medicines in a person-centred way, for instance they received their medicines as part of a set round, rather than at a time which met their personal needs. This is discussed further in the safe section of the report.

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.
• Care plans outlined how people's best to communicate with people, for example if their hearing was impaired.
• Whilst some staff followed the guidance in the care plans we observed that staff did not always communicate effectively, in line with good practice. We observed a member of staff trying to explain a pie to a person with dementia, rather than showing the food.

Improving care quality in response to complaints or concerns
• The manager used complaints to improve the service. Formal complaints were logged and responded to after an investigation.
• Despite the concerns outlined in the well-led section of the report, people and families told us they felt able to raise concerns with the manager and senior staff. For instance, they told us they spoke out in resident meetings and were listened to. A relative told us, "When we ask something of them for our family member they try to respond."

End of life care and support
• Staff worked with health professionals such as the local hospice to meet the needs of people who required palliative care.
• Care plans had some information about people needs and preferences at end of life. Families had been consulted. The end of life care plans were not highly personalised and there was scope to improve these in line with best practice, to ensure staff had the up-to-date and high-quality information to meet people's needs.

We recommend the service seek guidance about best practice in end of life care to enhance experience and safety of people receiving palliative care.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The lack of a consistent manager affected every level of the service and negatively impacted on people's quality of life. The registered manager at our last inspection had left. They had been replaced by a new registered manager who had also left. The current manager had been at the service for six weeks when we inspected. Feedback about the new manager was positive. A person told us, "I've met the new manager and they seem personable." Further time was needed to determine whether this appointment represented a more stable time for the service.
• Quality checks on were not effective and left people at risk. There was a high turnover of senior staff at provider level, for example within the quality team, which limited the providers ability to learn from mistakes and improve care in a consistent manner. The provider told us of a number of new appointments being made, such as a new housekeeper and clinical lead, to help support improvements at the service.
• Poor practice was not yet being managed effectively. The risk from sluice doors being unlocked was raised in a team meeting a week before our inspection, however one week later we still found sluice doors open. Many of the concerns we found, such as poor administration of medicine, had already been raised in an internal audit in April 2019 and in reviews by external professionals.
• After our inspection the manager sent us a thorough action plan which addressed the concerns we outlined in our report. In the past, the provider had failed to adequately implement similar action plans. Although we were assured the concerns we raised were in the action plan, further time was needed for the provider to demonstrate it was able to sustain improvements.

The provider had not ensured there were effective systems to mitigate risk to people's safety and to promote their welfare and wellbeing. The provider did not sustain improvements over time. These findings demonstrate 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 unsettled management of the service was reflected in the conflicting feedback we received from people. A person told us, "The managers need to sort things. Get those staff to be more friendly so you don't have to say, 'Come on, smile.' At the moment it's a job to them," whilst another person told us they did not

know who was in charge.
• In the responsive section of this report we discussed the poor social outcomes for people being cared for in bed. The provider had put measures in place for this care by setting up 1:1 sessions and employing five activity coordinators. However, poor management and lack of effective audits and checks meant the senior staff had not picked up when people did not receive care as the provider had planned.
• Some people were positive and hopeful about their future at the service. A person told us, "It has improved, from my point of view. This manager is open to what I have to say, I did not know the previous manager, so I have got to be happier than I was prior to the new managers arrival."
• Despite our concerns about the use of agency staff on the day of our inspection, two family members remarked on the increased stability with the recent reduction in agency staff. This confirmed the managers view that there had been improvements in this area.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
• There were regular meetings with people and their families. We looked at the minutes for these meetings and found they were open and informative.
• There was a short meeting each day where senior staff discussed main themes and any concerns. The manager also used this meeting to ensure staff knew what tasks they had to complete.
• During our inspection we found there was an open culture where people, families and staff felt able to speak with us. Staff spoken openly about their experience of working at the service and we were able to have positive discussions with senior staff.

Working in partnership with others
• Stakeholders gave us positive feedback about the new manager's commitment to working in partnership. We saw minutes of meetings and emails which outlined many of the issues we had found during out inspection and the actions being taken to address these.
• Staff were committed to working together with professionals to care for people.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured adequate systems were in place to protect people from the risk of choking, poor administration of medicine and spread of infection. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were effective systems to mitigate risk to people's safety and to promote their welfare and wellbeing. The provider did not sustain improvements over time.