Leicestershire County Care Limited

Huntingdon Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Huntingdon Court is a residential care home providing personal care to 36 people aged 65 and over at the time of the inspection. The service can support up to 41 older people.

People's experience of using this service and what we found
People were not always safe because risk was not identified or managed. Systems to protect people from abuse were not effective because concerns were not always identified, acted on, investigated or referred to appropriate authorities such as the local authority safeguarding team. Staffing numbers were not sufficient to meet people's needs or keep them safe. Some people were at risk of falling or had fallen when staff were not available to provide supervision and support.

People and staff were not always supported because the culture of the service was not person centred or open and did not always achieve good outcomes for people. Systems in place to monitor the quality of the service were ineffective. They did not fully seek or listen to the views and feedback from people, relatives and staff. The provider had failed to make enough improvements since our last inspection where we identified concerns.

People usually received their medicines in the right way and at the right time but there was a difference in staff understanding regarding when a person's 'as required' medicine should be administered.

Staff received induction training and ongoing training the majority of which was completed on-line and in the staff members own time. Records for staff induction training were not available so we could not be sure all staff had received all the training they required.

People had their risk of malnutrition assessed. However, action was not always taken when records showed they had insufficient amounts to eat and drink. People had access to healthcare services.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. There was an ongoing investigation at the time of our inspection which included concerns about deprivation of liberty. The provider had planned further training for staff about the Mental Capacity Act.

Most people and relatives praised the staff and said they were kind and caring. We saw staff supporting people in a kind and sensitive way and interactions were positive and respectful. However, staff did not always have the time to spend with people they required to meet their needs. Staff were extremely busy and often in a hurry. People were not fully involved in making decisions about their care and were not routinely asked about their care plan or preferences. People had their privacy and dignity respected.

Care and support was not person centred because care plans were not fully reflective of people's physical, mental, emotional and social needs. There were a range of activities on offer but these were not planned around people's preferred hobbies and interests. Complaints were not always taken seriously, acted on or used as an opportunity to learn and improve.

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 June 2019) and there were multiple breaches.

Previous breaches
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about risk and allegations of abuse and there was an ongoing police and safeguarding investigation. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the relevant key question sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to the identification and management of risk, staffing numbers, safeguarding people from abuse and quality monitoring. 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
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?

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

Huntingdon Court

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 by two inspectors.

Service and service type
Huntingdon Court 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 manager registered with the Care Quality Commission but they had left the service earlier in the year. There was an acting manager who had submitted an application to become registered as the manager with the CQC.

Notice of inspection
The first and third day of this inspection was unannounced. Day two was announced.

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. 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 used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and four relatives about their experience of the care

provided. We spoke with 18 members of staff including the acting manager, area manager, senior care workers, care workers and the housekeeper.

Inadequate

Is the service safe?

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 deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

We carried out an unannounced focused inspection of this service on 30 April 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and staffing. At this inspection we found the provider was still in breach of these legal requirements.

Assessing risk, safety monitoring and management

- Risk was not always identified or managed. For example, one person had been assessed as requiring constant supervisions and assistance because of their cognitive impairment. Care plans did not take this into account and did not manage the risks for this person who was frequently up during the night for long periods of time and was disorientated to time and place. Staff had recorded episodes of aggression but had not been instructed about the best way to manage this.
- One person chose to sleep in the lounge at night rather than use their own room or bed. They chose to sleep in an upright chair. The risks associated with this, such as developing pressure ulcers and potential discomfort where not identified or managed and were not referred to in the person's risk assessments or care plan.
- Another person had a history of falls and was at risk of falls. The care plan instructed staff to assist the person when they were walking. A staff member showed us how they did this by providing reassurance and gentle touch. They said staff had to 'keep an eye on [person]' as they might fall. We asked how staff could 'keep an eye on' person all the time, and the staff member said they couldn't, but 'we do our best'. They said the person needed constant supervision, but it was not possible with the current staffing levels. We later saw this person mobilising alone in a communal area and in the corridor with no staff in attendance. This meant their care plan was not being followed and this put them at increased risk of falls.
- Another person with a history of falls and assessed as at risk of falls was seen to spend time on their own in the upstairs lounge without any staff supervision during our inspection. The moving and handling assessment instructed staff the person required 'clear instruction to use their frame correctly' and should be reminded to stand up slowly because of a medical condition which caused dizziness on standing and was disorientated to time and place. This person had two falls in October and November 2019. On both occasions they were found on the floor having fallen when mobilising on their own.
- There had been 11 unwitnessed falls from September 2019 to the time of our inspection. The monthly audit of accidents and incidents had not sufficiently analysed any cause or effect or considered what action could be taken to reduce the incidence of unwitnessed falls. We were told there should be a member of staff in the downstairs lounge at all times so that people at risk could be monitored and supervised. However, this was not always possible when staff were busy with other people elsewhere in the home. There were also smaller lounges on the first floor which were used by people who had a history of falling and had been

assessed as at risk, they spent time without any staff supervision or monitoring. This meant the provider was not doing all that was reasonably practicable to mitigate risk.

The provider failed to ensure that care and treatment was always provided in a safe way. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment

● People were at risk of harm from inadequate staffing levels. We received feedback from relatives and staff that there were not enough staff deployed to meet people's identified care and support needs in a safe and consistent manner.

● Some staff said staffing levels at the service were too low, putting people at risk. A staff member said the start of the morning shift was a particularly risky time as people wanted to get up but there weren't enough staff to assist them. They said they were worried about people's safety.

● Another staff member said low staffing levels meant staff had to fill in daily records at the end of their shifts rather than contemporaneously (at the time or shortly after an event occurs). They said, "We are so busy with the residents that we don't have time to fill in the daily records when we should, we have to fill them in later. Most of the staff do this, it's impossible to do it any other way." This is not good practice as detail can be lost as a result.

● Another staff member told us they and their colleagues were very tired and very busy. There was no time to talk with people or safely monitor them.

● A staff member told us, at times people had to wait a long time to go to the toilet. They were very busy and had to rush. They felt there was an expectation to get everyone up by ten in the morning and to get people to go to bed early because there were not enough staff during the night.

● Relatives told us they were concerned about staffing numbers and did not feel there were enough staff to safely monitor or supervise people.

● The staffing levels determined by the provider did not take into account the dependency needs of people or the risks associated with receiving care. There were 36 people using the service. Nine people required 2:1 support for all transfers because they had been assessed as requiring a hoist or stand aid for mobility. 20 people were at risk of falling or had a history of falling.

● Staffing numbers determined by the provider were five care staff and two care team leaders during day time hours and one care team leader and three care staff at night. There were times when there were no care staff (or any staff at all) in communal areas or available to attend to people's needs or requests for assistance.

● At night at least four people were regularly up during the night. One person had been assessed as requiring constant supervision and staff had recorded episodes of aggression. Several people were at risk of falls and this increased the risk because staff were unable to observe them.

● One person, who was at risk at risk of falling at night had a sensor mat and door alarm to alert staff when they were up during the night. However, if staff were busy with other people they could not protect their safety. This person had a fall in the communal lounge at 21.45 when staff were attending to other people. Staff recorded they 'heard a bang' and found the person on the floor. They sustained a cut lip and bleeding nose and received treatment form a paramedic.

● Staffing rotas showed that the staffing numbers determined by the provider were not always achieved because of short notice absence and this put people at greater risk. On the night of 11 November one of the three night staff did not arrive for their shift and was not replaced. This meant there were only two staff on duty over -night and during this period, two people had falls. Both had a diagnosis of dementia and were found on the floor by staff.

● Fire evacuation records showed that 15 people required physical assistance to evacuate and 18 people

required walking aids and verbal prompts to evacuate in the event of a fire. Two or even three staff would not be able to achieve a safe evacuation in the event of a fire based on this assessment of people's needs.

The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● We looked at five staff member's files to see if they had been safely recruited. Staff had completed application forms, supplied references, and undergone criminal records check before they started work at the home.
● Records showed two of the five staff files we saw were audited by the provider in October 2019. The audit showed that both contained information that should not be kept by the home under data protection laws, one application form hadn't been signed, and there was no job description in one file. The provider's representative manager said these shortfalls were being addressed.

Systems and processes to safeguard people from the risk of abuse
● One person said a [named] staff member was 'very strict' and 'told off' people living with dementia for their behaviour. We reported this to the local authority for investigation and made the acting manager aware we had done this.
● Following our inspection we received information about an allegation of abuse which had been reported to the acting manager. The acting manager had not investigated the allegation or reported the allegation to appropriate authorities. This meant people were not protected.
● Two staff members did not feel confident about raising concerns and did not feel appropriate action would be taken or they would be treated fairly.
● Other staff we spoke with knew how to report safeguarding concerns and said they would do so with confidence. One staff member said staff had reported a colleague to management due to them being 'rough' with people, and as a result the staff member no longer worked at the home.
● A relative told us they had raised concerns with managers over a period of time but did not feel they were properly investigated.
● We saw from meeting minutes that concerns had been raised at a relatives meeting held by the provider on 8 November 2019 but these had not been investigated any further at the time of our inspection. The provider's representative said they would follow this up when we pointed this out.
● Other people and relatives said they had no concerns about the staff. A relative said, "I have never seen staff being inappropriate to residents."
● Some staff, for example ancillary staff, were not trained in safeguarding even though they had contact with people using the service. We discussed this with the provider's representative who said they would address this.
The provider failed to protect people from abuse because systems and processes were not operated effectively.

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) 2014.

Using medicines safely
● People mostly had their prescribed medicines in the right way and at the right time.
● One person's protocol for administering their 'as required' medicine was contradictory and staff were not clear about the circumstances in which this should be given. The person's care plan records stated it should be given to help with sleeping at night but the protocol stated it should be given when the person was

wandering around and their speech was incoherent. Staff told us the person walked around the home and had incoherent speech on a day to day basis and this was normal for them. We also saw staff recorded they had given this medicine to manage aggression. Staff contacted the person's doctor to clarify this medicine should be given after we pointed out our concerns.

● Other records for medicine administration were accurate and up to date.

● Medicines were stored correctly and securely. Staff made sure the temperatures of medicines requiring refrigeration were within safe limits.

● Staff knew what action to take in the event of a medicine error and this included seeking medical assistance.

● Staff had received training and had their competency to manage people's medicines assessed.

● Audits were carried out and these identified some errors and shortfalls and action was taken to make improvements.

Learning lessons when things go wrong

● Action was taken following accidents and incidents such as introducing assistive technology such as motion sensors to alert staff. However, there was insufficient analyses of accidents and incidents and action taken had not been sufficient to identify or reduce ongoing risk.

● We identified breaches to our regulation at our inspection in April 2019. The provider was still in breach of these regulations at our inspection November 2019. This meant the provider had not taken sufficient action when things went wrong and did not learn lessons in order to improve.

● The provider's representative told us concerns and issues were discussed at manager's meetings so that lessons could be learned when things went wrong within the organisation and from the sector as a whole. The provider used an initiative known as 'theme of the month' to inform staff about best practice in areas where things had gone wrong. For example, the theme at the time of our inspection was 'oral health' and this was in response to learning in this area.

● The provider had arranged additional training for staff in response to allegations of abuse. This was due to take place soon after our inspection.

Preventing and controlling infection

● The home was clean, tidy and fresh. A relative said, "The home is always clean."

● Staff were trained in infection control and basic food hygiene. Staff used protective clothing, for example gloves and aprons, when they needed to.

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 good. At this inspection this key question has deteriorated to requires improvement. 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

- People had their needs assessed before moving to the service. This included people's physical, mental health and social needs. However, the moving and handling risk assessment and falls risk assessment for one person who had been at the service for over three weeks had not been completed.
- The acting manager told us they kept up to date with best practice standards, guidance and the law through training, team meetings and updates from the provider.

Staff support: induction, training, skills and experience

- Most training was provided on-line and staff were expected to complete this in their own time.
- A member of staff told us they had recently completed on-line training. They were unsure whether all of their training had been completed and told us they had to complete the training between their shifts when they were not at work.
- We looked at five staff member's training records. Of these only one member of staff was recorded as having a full induction. The others had no records, or only partial records, of an induction being carried out. This meant we could not be sure new staff had the skills and knowledge they needed to begin work in the home. The provider's representative said all these staff had had a full induction, but it had not been recorded by the staff member responsible for doing this. They said in future induction records would be kept.
- One staff member we spoke with did not understand or was not aware of 'whistle blowing' or the provider's policy for this.
- Another staff member told us they had not received training about safeguarding people from abuse or the Mental Capacity Act 2005.

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

- Records for one person identified at nutritional risk and risk of dehydration showed minimal intakes of food and fluid and did not specify the amount of fluid this person required. Their care plan instructed staff to ensure they had a healthy diet with an adequate fluid intake.
- Food and fluid charts had not been checked or any action taken when insufficient amounts of food and fluids were recorded.
- This person's weight was very low and was being monitored but no further action had been taken or further advice sought from a healthcare professional. We observed this person had their lunch on their own and was not offered any assistance or supervision. They only ate a few mouthfuls of their meal.
- Most people had their meals in the communal dining room. People enjoyed their meals and the

atmosphere was relaxed and social.
● A staff member supported one person to have their breakfast at mid-morning. They enabled the person to take their time and warmed up their breakfast when it went cold.
● The person had food and drink at a specified consistency to reduce the risk of choking. The staff member was knowledgeable about this and used a thickener appropriately.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● People had a hospital grab sheet care plan. This was designed to send with people in the event of a sudden hospital admission and contained important information about the person. The grab sheet care plan for one person was partially completed. There was no information about their communication needs despite the person having difficulty with communication. This information is important so that hospital staff would understand the best way to communicate with the person.
● We spoke with a visiting community nurse. They told us staff had been very helpful and followed their advice and guidance.
● Staff knew how to recognise when people's health was deteriorating and contacted medical professionals when required.

Adapting service, design, decoration to meet people's needs
● The service was accessible with appropriate signage to assist people in finding their way around.
● There were a range of communal areas and outside areas that people could access.

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).
● People had their capacity to make decisions assessed. The acting manager told us they were improving their mental capacity assessments so that capacity was considered for specific care interventions.
● People had appropriate authorisations in place when their liberty was restricted.
● We spoke with a visiting deprivation of liberty assessor. They told us they were satisfied staff were following the principles of the Mental capacity Act 2005.
● A staff member told us how they supported one person who had a DoLS restriction in place using distraction techniques to encourage them to receive personal care. They said, "You have to gain [person's] confidence as they are a very private person."
● Another staff member, supporting a person with their breakfast, ensured they had the person's consent, asking, "Shall I push your nearer to the table?"
● There was an ongoing investigation at the time of our inspection which included concerns about deprivation of liberty. The provider had planned further training for staff about the Mental Capacity Act.

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.

At the last inspection this key question was rated as good. At this inspection this key question has 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 said most of the staff were mostly caring and kind. However, one person raised a concern about the attitude of one staff member which we have addressed under 'Safe'. They also said, "The night staff don't speak to us much. They are always busy upstairs."
- Some people said they had built up good relationships with staff members. A person told us, "[Staff member] is really nice and has a laugh with us."
- Relatives said the staff were caring. A relative said, "The staff are very kind and caring, they are what makes the home. My [family member] has built up lovely relationships with staff. [Family member] gets on particularly well with [senior carer] and [housekeeper])."
- Staff said people's well-being was their priority at the home. A staff member said, "I'm here for the residents, not anyone else."
- Staff gave people reassurance when they were distressed. People responded to staff in a positive way. However, staff were not always available. Staff did not have time to spend with people. People did not always get the assistance they required because staff were busy assisting other people.
- A visiting healthcare professional told us staff had been very supportive to a person who was anxious about their treatment.

Supporting people to express their views and be involved in making decisions about their care
- People said they were not involved in their care plans.
- Relatives said they were involved when care plans were first written but not since. They said they would like to have the option of being involved when their family member's care was reviewed.
- Staff used a document known as a 'listening form' to record when they had asked people for their feedback. This process had recently been introduced. We were told one person had requested to go out more frequently and this was arranged.

Respecting and promoting people's privacy, dignity and independence
- Staff had received training about respecting people's privacy and dignity. They gave us examples of how they did this when providing personal care.
- A person said they had the option of a male or female staff member for personal care which they appreciated. The person said, "I prefer a male carer. [Staff member] is a very nice person and very kind. They don't rush me. They just stand outside while I'm showering to make sure I'm okay."
- A staff member promoted a person's dignity and independence when supporting them with their

breakfast. They communicated with the person clearly and kindly, using their name to get the person's attention. They told us, "[Person] is very independent and want to do things for themselves. We encourage them but at the same time we have to be careful that they're safe."

● Information about people was stored securely and staff kept information confidential, only sharing with appropriate people. The importance of this had been discussed at the last staff meeting.

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 has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- People had their needs assessed before they moved in. Each person had a care plan to instruct staff about the care and support required. However, care plans were not fully reflective of people's physical, mental, emotional and social needs.
- One person was frequently up during the night, but their care plan made no reference to this or any guidance of what staff should do to encourage sleep and rest for this person.
- Another person preferred to sleep in a chair in the lounge at night. The risks associated with this and their preferences for rest and sleep were not referred to in their care plan.
- This meant people may not have their needs fully met or receive support in the way they preferred.

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.

- Some people had difficulty with verbal communication. Care plans did not instruct staff about the most effective way to communicate or suggest any communication aids such as using pictures to assist the people to communicate.
- One person who had communication difficulties had some pictures in their room which a relative had provided to assist with communication. However, staff did not use these pictures while the person was in the communal areas throughout the day.
- A person said, "Sometimes I can't understand what the staff are saying because they can't speak English." The provider's representative said only staff who could communicate effectively in English were employed at the home, and this was determined when they were interviewed.

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

- Staff provided a range of activities for people. A person said staff took some people to a recent Remembrance Day parade and then for a coffee which they enjoyed. People and relatives said they did arts and crafts at the home and entertainers visited.
- A staff member played a floor game with a group of people. The staff member ensured that everyone who wanted to be was included. People enjoyed this game and were laughing and joking with the staff member as they tool their turns to play.
- Information about people's hobbies and interests was limited. This information is important particularly

when people have difficulties communicating their needs. There were no examples of people pursuing their lifelong interests or hobbies.

Improving care quality in response to complaints or concerns

● There were no records of complaints received. This is despite two relatives telling us they had made complaints in the recent past. This meant people may not be supported when making a complaint and opportunities for learning and improvement may be missed.

● People said they would tell a member of staff or a manager if they had any concerns or complaints about the home. A person said, "If something was wrong I would tell [the maintenance person]." They said this was because they got on well with this staff member.

End of life care and support

● Staff had received training about end of life care. There was nobody receiving end of life care at the time of our visit.

● Staff did not routinely explore people's advanced care planning preferences. This information if available would assist staff to provide the end of life care the person preferred.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now, deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The acting manager and area manager carried out regular audits to check staff were working in the right way to meet people's needs and keep them safe. Governance and auditing was not always effective and had not identified the risks and concerns identified at our inspection.
- Systems for identifying, capturing and managing risks and issues were ineffective. There were continuing staff shortages caused by late notice absence with ineffective contingency plans to provide staff cover. Staffing numbers determined by the provider were frequently not met and were not calculated using a recognised staffing or dependency tool. Risk was not always identified or managed, people had fallen because there were not enough staff to supervise people and make sure they were safe. Safeguarding procedures did not protect people from abuse.
- Audits had identified the carpet in the office required replacing because it was heavily stained. Staff were unaware of when this would be done.

The provider failed to ensure they had effective systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people. This was a continued 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

- There was an acting manager in post. They had applied to become registered with the CQC.
- At the time of our inspection there was an ongoing investigation by the local authority and police about allegations of abuse and poor practice.
- We had a mixed response from staff about the support they received from their managers. Some staff felt they were supported but others felt they had raised concerns but no action had been taken.
- Staff and relatives told us they had expressed their concerns about low staffing numbers but no action was taken to increase the numbers.
- The provider's representative told us they had introduced unannounced spot checks during the night so they could check care and support was delivered in the right way. Spot checks were taking place weekly and at different times during the night shift.
- Staff received supervision with their managers and had access to on line training. Staff did not get paid for training and were expected to complete this in their own time.

● Staff said the staff team mostly got on well. Two staff members said there was 'tension' in one part of the home because a language other than English was spoken. They said the current acting manager and the previous registered manager told the staff in this part of the home to speak in English, but they continued not to do this. The staff members said this made communication and team-working difficult.
● Another staff member said the staff team was multicultural and worked well together. They said, "We are like a family. I love the atmosphere here, the people, and the staff."
● A relative said, "[Acting manager] has always been particularly fond of my [family member] and warm to me. Whenever I've gone to them I have never made to feel like a nuisance."
● A staff member said the acting manager was approachable and easy to talk with. They said, "If I had a problem I would got to [acting manager]."

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
● A meeting for peoples relatives had taken place to provide people with information about the current allegations and investigation. A further meeting was also planned.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●Engagement with people, staff, the public and community was minimal.
●Meetings were held for people and staff. Meeting minutes we saw did not provide any examples of changes being made in response to feedback.
●People and staff who raised concerns were not always supported or taken seriously.
● Satisfaction surveys were sent to people annually to ask for their feedback.
● Feedback and action taken in response to people's feedback was displayed in the reception area. However, the information displayed was more than two years old. The acting manager began to address this and update the information during our inspection.

Continuous learning and improving care
● We carried out an unannounced focused inspection of this service on 30 April 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show us what they would do and by when. At this inspection we found the provider was still in breach of these legal requirements. The provider had failed to use the findings of the inspection to drive improvement.

Working in partnership with others
● Visiting health professionals were complimentary about staff and found them supportive and helpful.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Concerns were not always taken seriously, investigated or acted on.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk was not identified or managed. The provider was not doing all that was reasonably practicable to mitigate risk.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and auditing was not always effective and had not identified the risks and concerns identified at our inspection.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers were not sufficient to meet people's needs or keep them safe.

The enforcement action we took:

Warning Notice