Anchor Hanover Group

Buckingham Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Buckingham Lodge is a residential care home providing personal care to 37 people aged 65 and over at the time of the inspection. The service can support up to 64 people.

The service is purpose built and accommodates people over three floors. Each unit has its own lounge, kitchenette, dining areas and bathroom. Alongside this the service has a cinema room, hairdressers and family room. The ground floor unit provides care to people living with dementia, whilst the first floor provides residential care. The second floor supports people with residential and dementia care needs.

People's experience of using this service and what we found
We received mixed feedback on the care provided. People were generally happy with their care and felt safe. However, some of their feedback on staff practice, staffing levels and activities indicated safe care was not consistently provided.

Risks to people, including infection control risks were not always identified and mitigated. Systems were in place to safeguard people. However, staff practice and reduced staffing levels had the potential to put people at risk.

People were not supported by sufficient numbers of suitably trained staff. Staff described working under pressure and unsupported on shift which impacted on the quality and timings of people's care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice

The service was not consistently managed, and auditing was ineffective in bringing about improvements to the service. Records were not accurate, accessible and suitably maintained.

Systems were in place to ensure staff were suitably recruited. We have made a recommendation to improve recruitment process to include photographs of staff and show evidence that they have explored gaps in employment.

The provider had a duty of candour policy in place, although records were not available to evidence the service worked to the policy and the regulation. The interim manager confirmed this would be addressed for future incidents and provided us with an action sheet to show how that would be monitored.

Medicines were safely managed, and systems were in place to monitor accident and incidents.

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 19 July 2019) and the provider was in breach of two regulations of the Health and Social Care Act 2008. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection 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 people's care and staffing levels. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, staffing, safeguarding, good governance and the application of the Mental Capacity Act 2005.

We served warning notices in respect of breaches of Regulation 12, 17 and 18 of the Health and Social Care Act 2008 with a timescale for compliance. The progress with meeting these regulations will be reviewed at the next inspection.

Please see a summary of the actions we have told the provider to take at the end of this report.

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.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Buckingham Lodge

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector on site over two days and an Expert by Experience on day two. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

A second inspector assisted with telephone calls to staff after the inspection.

Service and service type
Buckingham Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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. The registered manager was away from the service at the time of our inspection. A manager from another Location and a regional manager was supporting the service.

Notice of inspection
This inspection was unannounced, with notice given by telephone from the car park on day one of the inspection.

What we did before the inspection
We reviewed notifications sent to us and other information of concern we had received. 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 eight people who used the service and three relatives about their experience of the care provided. We spoke with 13 staff which included the interim manager, regional manager, district manager, three team leaders, five carers, head of housekeeping and the wellness coordinator. 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 the environment and a range of records. This included 10 people's care records and 11 medication records. We looked at five staff files in relation to recruitment. A variety of records relating to the management of the service, including audits, health and safety, accident and incidents and complaints were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, rotas, allocation records and policies and procedures. We spoke with six relatives and seven staff. We requested contact details for professionals who visited the service. None were provided and therefore their feedback was not requested.

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

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) 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.

● Some risks to people were identified and mitigated, whilst other risks were not identified. For one person a known risk of fluid retention was identified, and a risk assessment had commenced but was not completed to include control measures to mitigate the risk. Risks around medical conditions such as seizures, absences and diabetes were not fully mitigated. For a person with diabetes their care plan made reference to hypoglycaemic symptoms but there was no reference to hyperglycaemic symptoms and the action to take.
● In one person's file we saw they had experienced a seizure and was admitted to hospital. There was no risk assessment in place to identify and mitigate the risk. For another person staff told us they had 'absences' which it was believed was caused by dehydration. Their care plan made no reference to this. Fluid charts were in use but there was no guidance as to what was the required daily fluid intake for this person to prevent dehydration and mitigate the risk of them experiencing an absence episode. In response to the draft report the provider disputed the staff members summary of the person's needs. However, it is a concern that a staff member supporting the person did not know their needs and risks.
● The risk of dehydration for people due to the warm weather had been considered and fluid charts were in use. However, the minimum fluid intake for individuals was not outlined and as a result the risk of dehydration had not been mitigated as the fluids charts showed variances in the fluid intake for individuals. For example, on occasions some people only had a minimum of 400 millilitres of fluid recorded over 24 hours.
● Prior to the inspection we were informed that risks surrounding a person's medical diagnosis and changes in the appearance of it had not been identified and managed which led to a deterioration in their condition. This was under investigation by the Local Authority safeguarding team and the provider. We are reviewing whether the incident meets the threshold for a specific incident that we can take action on.
● One relative provided us with examples where their family member did not get the care required to mitigate risks to them. They questioned whether staff had the skills to deal with their family members distress and frustration, which they believed resulted in their family member been left in bed for long periods of time which increased the risk to them of falls and skin breakdown. They told us that they had

requested assistance at meals times and a soft diet for their family member due to their difficulty in eating normal meals. The person's care plan on nutrition indicated the person was able to eat and drink on their own and there was no documented evidence to demonstrate the relative's concerns had been explored. Therefore, we could not assured that any potential risks around meals were mitigated. We informed the provider of the relatives concerns for them to address. They confirmed a referral had been made to the Speech and Language therapist to further assess and mitigate any potential risks.

Risks to people were not always mitigated. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not fully assured the provider was meeting shielding and social distancing rules. No signage was in use to promote social distancing and the communal areas of the home were not set up to promote social distancing. Armchairs were placed side by side in communal areas of the home and in the staff room. Management told us it was difficult to promote social distancing as people moved the chairs back and as it was their home it was felt less necessary. On day two of the inspection some social distancing notices were in place and in some areas of the home armchairs were set up further apart. However, on one unit we saw four people were seated at the dining table together and staff failed to promote social distancing when engaging with each other. A staff member commented, "Social distancing efforts were priority and practised at first, chairs were moved to be further away and only two residents sat at lunch tables but that has all been relaxed now and it is back to where it was before COVID -19."

● We were not fully assured that the provider was using PPE effectively and safely. The service had access to sufficient PPE however, throughout the inspection we observed masks were not always worn correctly and a contractor to the home was not wearing a mask. A staff member was observed to have long manicured nails which was not in line with infection control guidance.

● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service had cleaning schedules in place which indicated high touch areas were to be cleaned three times a day. The cleaning records showed high touch areas were cleaned once a day only and staff spoken with were not aware of their responsibility to regularly clean high touch areas and record. The service had communal toilets with a notice on the door stating that the doors were locked due to COVID -19 and that people should request help and be accompanied if they wished to avail themselves of the facility, so it could be sanitized between uses. However, we saw the toilets were unlocked and freely used by people during the inspection with no sanitising of the toilets in between use. The provider confirmed in response to the draft report that the signage should not have been in use and was removed.

Infection control risks were not always mitigated. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat that the provider was preventing visitors from catching and spreading infections. On day one of the inspection screening checks were not completed on us, other than for us to confirm the results of a lateral flow test. When asked about this we were told the organisation did not carry out temperature checks on visitors and that they had overlooked the other checks on us such as completing a questionnaire. On day two of the inspection the checks were completed prior to us entering the service, which included a temperature check. The provider reassured us that systems were in place to promote safe visits.

● We were assured that the provider was admitting people safely to the service.

● 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 were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. People and their relatives confirmed visiting had commenced and throughout the inspection we saw this was promoted with visits pre booked and facilitated.
● Health and safety checks took place and equipment such as the lift, fire equipment, gas, electricity and hoists were serviced. People had personal emergency evacuation plans (PEEPs) in place and regular fire drills took place.

Staffing and recruitment
At the last inspection we recommended that the provider keep the staffing levels under review to ensure they have suitably skilled staff available to meet people's needs.

● People were not supported by sufficient, suitably skilled staff. People, relatives and staff told us the staffing levels were not sufficient and consistent. People commented, "The staff are alright, but more are needed. You can tell they are short sometimes," they added "I find all the carers alright, but they chop and change a lot," "I think they are short of staff and they certainly need more carers on a Sunday, "and "Staff do their best, but some days are not so good, sometimes they are short, very short. Staff tell us they are very busy, and some people do not get the treatment and support when they want it."
● Relatives commented, "For a long time they have been very short staffed and were very short of night staff," and "Sometimes there is no one around at 2pm and at weekends they always seem short staffed, rushed and under pressure."
● Staff told us the staffing levels per unit were not sufficient to meet the dependency levels, especially on the ground floor, where six out of 11 people required two staff to support with personal care. Staff confirmed there was no management support especially at the weekends and that some team leaders and management did not assist on shift and had no consideration for the pressure they worked under. Staff told us that on occasions there was not a team leader on each unit with the team leader working across two units without extra staff provided to support and cover. Two staff members told us they often left work in tears because of the pressure of the shift. Staff told us the impact of the lack of staff meant people were left in bed longer than they wanted to be and there was a delay in people getting their meals as six people on one floor required staff assistance and generally only two staff were provided.
● The provider confirmed dependency levels were kept under review and sufficient staff were provided. They acknowledged there was a high use of agency staff and on occasions agency staff booked on a shift did not turn up which impacted on those shifts. They were working with the agency to address the short notice cancellations and no shows and continued to recruit into the vacant positions.
● The interim manager confirmed the required staffing levels were three team leaders and eight care assistants on the day shift and one team leader and five care assistants on the night shift. On review of the rotas we found that the staffing levels deemed as required by the provider were not provided. The rotas and allocation records viewed, showed from the 2 June 2021 to 20 June 2021 on 26 out of 57 shifts the required staffing levels were not maintained. Carers were allocated to work across floors on a shift and there was 15 day shifts where only two team leaders were on duty, sometimes with only six or seven carers. There was two day shifts where there was only one team leader on duty, although two extra carers were provided on these shifts. The rotas showed a high use of agency per shift with occasions where six out of the eight carers on duty were agency staff. In response to our draft report the provider confirmed the minimum staffing was two team leaders and seven care staff on the day shift and one team leader and four care staff on the night shift. However, the rotas and allocation sheets for the period of the 2 June to the 20 June 2021 showed 11 shifts where the minimum staffing the provider told us was required was not provided.
● Care staff's role included facilitating in house one to one and group activities. Care staff told us they did

not have enough time on shift to care for people and therefore the activities provided were limited and infrequent. Some people told us the activities provided did not interest them and were not regular. People commented, "I have been a resident here for four years. When I first came there were lots of things to do but I tend to sit in my room most days now," and "There is not much going on here, we have sat here since lunch and haven't moved." A relative told us their relative was not provided with any stimulation such as one to one activities or group activities. Another relative commented, "Family member had no meaningful interactions over the year, which had contributed to the deterioration in their mental health."

● Staff told us they had access to regular training but did not feel the quality of the training on 'supporting people when distressed' equipped them for their role. Other staff could not recall having this training even though they supported people who became distressed and uncooperative mainly , during personal care. The training was provided internally and was not included on the training matrix. Therefore, we were not assured that the service knew which staff had the training to equip them for their role. A staff member commented "The training is hit and miss, and I do not feel they have enough time to train you." The training matrix did not evidence specialist training on medical conditions such as epilepsy, diabetes, Parkinson's or end of life care was provided. It showed only 50% completion for the Care Certificate training and the lack of management oversight of staff meant there was no assessment of learning to ensure training was embedded into staff practice.

● In response to the draft report the provider disputed staff's feedback on the training provided and confirmed staff had access to specialist training, although it was not logged centrally on their training records.

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always provided to provide safe and consistent care to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to promote safe recruitment practices. Potential candidates applied online and uploaded their curriculum vitae which outlined their work history. They were interviewed and pre employment checks were carried out. These included references from previous employers, a medical questionnaire and disclosure and barring service checks (DBS).

● In one of the staff files viewed only one reference was on file. This was available and added after the inspection. In another staff file gaps in employment were not explored and three of the five staff recruitment files viewed did not include a recent photo

It is recommended the service works to best practice and own recruitment procedure to ensure staff are suitably and safely recruited.

Systems and processes to safeguard people from the risk of abuse

● People were not always safeguarded. People told us they felt safe but provided us with feedback which showed mixed experiences on their care. A person commented, "I feel safe living here. Most of the carers are very kind there is no doubt about that," However they commented, "I haven't got patience with a couple of them and I notice some of the other people can get quite frightened by staff's approach." Another person commented, "I think one or two of the carers can be quite sharp and should be watched." They went on to tell us how a staff member had pulled their curtains across when they did not want them shut. They commented, "I just said leave them as I didn't want them pulled. However, they told me to 'mind my own business' and just carried on, didn't listen and was sharp with me."

● Some relatives were not confident that their relative received safe care. A relative told us of incidences where their family member had unexplained bruising and did not get the care required which had impacted on their well-being. They told us during a recent visit staff were asked to tend to their family member. Two

carers attended but one of them left almost immediately as felt unable to support the person. They left the person's bedroom without getting another staff member to support, which had the potential to put the person, relative and the other staff member at risk.
● Prior to the inspection we received information of concern about staff practice and moving and handling techniques. The provider was informed to enable them to investigate the concerns and make the required safeguarding referrals.
● The provider had safeguarding policies and procedures in place and staff were trained in safeguarding. During discussion with us staff indicated they were aware of their responsibilities to report poor practice. However, the feedback from people and their relatives indicated that staff behaviour, practice and staffing levels did not always safeguard people. A staff member commented, "I am concerned sometimes, my colleagues are often under pressure and they don't have time, then they don't respect people's wishes and don't agree to what the person actually want." Another staff member commented, "I would report concerns to the Care Quality Commission (CQC), as the management in the home are unapproachable."

People were not safeguarded from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other relatives we spoke with felt their family member was safe. A relative commented, "Yes, [family member's name] is safe living at Buckingham Lodge. Safety is one of their paramount things. If they ring their call bell staff come quickly. She did fall over in her room and the carers dealt with it quickly". The relative concluded, "One hundred per cent, absolutely the best thing for us and them is that they are living at Buckingham Lodge."

Using medicines safely
●Systems were in place to promote safe medicine administration practices. Medicines were suitably stored and at the recommended temperature. Records were maintained of medicines ordered, received, administered, disposed of and people's allergies were highlighted to mitigate risks to them.
● The provider had a medicine administration policy in place to promote safe practices and the team leaders involved in medicine administration were trained and assessed as competent for the task. Stock checks of medicines took place to enable any discrepancies in medicines to be dealt with quickly to minimise risks to people. The medicine administration records viewed showed medicines were given as prescribed with no gaps in administration.
● Protocols were in place for when "as required medicines" were to be administered and topical administration records were in use which outlined where prescribed lotions and creams were to be applied and showed they were signed and administered. A full audit of medicines had taken place prior to our inspection but the report on that was not available during the inspection.
● During the inspection we observed medicines being administered. We noted the team leader was not wearing the tabard to prevent them being disturbed during medicine administration. They told us people took no notice of the tabard and disturbed them anyway, and the day was too hot to wear it. The provider was made aware of this to follow up and monitor.

Learning lessons when things go wrong
●The service had systems in place to record accidents and incidents. Accidents and incidents were discussed at the handovers and daily morning meeting with heads of department. This ensured the staff were informed who was on post falls check and monitoring. We saw the 72-hour post fall monitoring was completed for individuals, following a fall.
● The interim manager confirmed Incidents, complaints, safeguarding's were logged on the providers event

capture system. These were reviewed, actioned, or closed by the home manager or deputy manager. Following the review of the incident, if there were learnings to take from the incident, or safeguarding alert. The interim manager told us these were shared with team leaders to discuss and share with their teams during handovers.

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

At our last inspection records were not fit for purpose, systems and processes were not established, operated effectively and audited to ensure the delivery of high-quality care. This was a breach of regulation 17 (Good Governance) 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 17.

● The service was not safely managed and appropriately audited to mitigate risks and meet regulatory requirements. The provider did not have a quality governance policy in place but had a schedule of audits which were required to take place. Systems were in place to audit aspects of the service. However, we found the care plan audits did not identify the issues we found with risk management and lack of mental capacity assessments. Infection control audits were picking up some issues but not all, and actions from those audits were not delegated and actioned. Staff recruitment files and rotas were not audited and therefore the issues we found were not addressed which compromised people's safety.
● The service had an action plan in place, but it did not include actions from in -house audits such as infection control audits. Some actions were outstanding on the action plan for six months. The provider confirmed in response to the draft report that outstanding actions have been uploaded to the universal action plan with target dates set for completion of actions.
● People's care records were not always contemporaneous, accurate or complete. A person's care plan was contradictory as to whether their diabetes was insulin or diet controlled. Some handwritten daily records were illegible, not dated and fluid charts were incomplete with total fluid intake over the 24 hours not routinely recorded.
● Some records relating to people's care were not on file. These were printed off and made available to us, However, they were not accessible to staff prior to our inspection.
● Staff recruitment files were in paper format. However, on review of the staff files not all the information was contained within them, which meant two systems were being used and the information was not easily accessible and suitably maintained. The provider confirmed all information on staff files was available.

The service was not suitably audited, and records were not properly maintained to mitigate risks to 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

● At the time of the inspection the registered manager and deputy manager were absent from the service. The service was being supported by a manager from another location and a regional manager was covering the deputy managers role. The service had five registered managers since been registered with the Commission in April 2015 which had led to inconsistency in the management of the service.

● People, relatives and staff found the management changes unsettling. A person commented "I certainly do not know who is in charge here." People were mainly positive about the registered manager. However, some relatives told us issues raised with the registered manager were not dealt with to prevent reoccurrence. A relative commented "[Registered managers name] dealt with our complaints. At the time management and staff all say sorry and promise to investigate and reassure us that they will research and change things for the better but, with [Registered managers name] nothing changed, it never did and it gets very frustrating and I don't know what to do." They commented, "I am being heard but then realise I am not being heard, I feel lost and I don't really know what to do." Another relative told us the registered manager failed to action their requests regarding their family members care which resulted in a deterioration in their family members medical diagnosis. They commented, [Registered managers name] showed no compassion towards us and were dismissive of our concerns."

● Staff gave mixed feedback on the approachability of the management team. They found the constant management changes within the service unsettling which they believed meant the service was not well led and managed.

●Staff told us they felt unsupported, undervalued and described the staff morale as low with poor communication and no teamwork. Staff commented, "There is no teamwork now, the team leaders tend not to be seen and are no help when we are so understaffed anyway. All they say is 'do this' or 'do that. People know and notice too," "There is no management support especially at the weekends and we are left to get on with it without regular staff, guidance or team leaders to support." and "Everyone raises staffing issues with management, but it falls on deaf ears, they couldn't care less."

● Staff found the staff in temporary management roles approachable and helpful, but the impact of their presence was not yet felt by staff. The provider confirmed in response to the draft report that systems were in place to engage with staff to seek their feedback and staff are recognised for their contribution to the service.

Good governance was not established, and the service was not suitably managed to provide good outcomes for people. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Continuous learning and improving care

● Systems were in place to get feedback from staff and people who used the service. People surveys were carried out for 2019/ 2020 and a staff survey was completed in 2019. The feedback from those raised similar issues that we found at this inspection around staffing levels, activities, training, management support, poor communication and lack of teamwork. The provider confirmed in response to the draft report that their internal inspection carried out in February 2021 sought feedback from people and their relatives with positive feedback provided then and on the care home UK website.

● Staff were trained in equality and diversity however, some staff told us they felt discriminated against which made them fearful of raising concerns. The provider confirmed in the response to the draft report that issues of discrimination in any form are not tolerated within their organisation and are treated with the

utmost of severity. No such issues or allegations have ever been brought to their attention at the service to enable them to act on it.

● We received mixed feedback from relatives around the services engagement with them. Relatives found the zoom calls invaluable during the pandemic whilst other relatives felt they were not informed of management and staff changes and some relatives felt communication was generally poor. The provider provided us with evidence after the inspection to show they had liaised regularly with relatives on zoom calls and with email updates.

● Handovers took place, but staff told us the communication within the home was poor. Staff told us team meetings did not take place regularly. Staff commented, "We have had two staff meetings over a year. Communication is poor," and "There have not been any staff meetings I am aware of and communication is non-existent." Copies of team meetings and clinical meetings were requested but not provided. The provider confirmed in response to the draft report that team meetings had taken place but had reduced in frequency due to the pandemic. They also indicated other forms of communication were in place such as Facebook group and the service's copies of communications was printed off and shared in addition to the 10 at 10 meetings and handovers.

● Whilst staff had received training considered mandatory by the provider, there was no observation of staff practice to ensure the training was understood and applied to practice. During the inspection, we observed staff moving and handling people. Whilst the manoeuvre was safe staff failed to engage with the person and explain to them what they were doing. The provider confirmed after the inspection that moving and handling training details in very clear terms how to interact with people appropriately. Throughout the inspection we observed staff referring to people as "darling, love, lovey and hun," without any consideration as to if that was how people wished to be addressed.

● Staff told us they felt unsupported and were not provided with regular one to one supervision. The supervision matrix provided showed a number of staff had received one to one supervision in March and April 2021 only. The providers policy indicated that colleagues should have regular one-to-ones and/or care supervisions (where applicable) to discuss their performance, set realistic objectives and provide any training or support needed to help them perform well in their role. However, the frequency was not defined, and staff were not feeling supported or trained for their roles to promote continuous learning to improve care.

Good governance was not established to engage with people, relatives, staff and to promote continuous learning to improve care. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Throughout the inspection we observed one staff member in particular showed exceptional positive engagements with people. They anticipated people's needs and their engagement with people was gentle, kind, reassuring, caring with good use of eye contact and touch. A person described the staff member as "a beacon and different to others."

● Staff involved in mental capacity assessments were trained. However, the records viewed showed a lack of understanding and application of the Mental Capacity Act (MCA) 2005.

● Decision specific MCA and best interest decisions were not routinely completed for people who lacked capacity to make decisions. For example, people who lacked capacity did not have a mental capacity assessment completed for aspects of care and treatment such as medicine administration, personal care, use of sensor mats and living at the service.

People were not consented with on their care. This is a breach of regulation 11 (Consent to care) 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

● The provider had a duty of candour policy to support staff in meeting the regulation. It indicated a face to face meeting should be offered with the person and/or their relative and this should be followed up with a written explanation and apology following a safety incident.

● We requested the duty of candour letter for a notification which indicated the duty of candour was applied. This was not available. The interim manager confirmed that an action sheet had been put in place to ensure the regulation was complied with and records maintained for future duty of candour incidents.

Working in partnership with others

● The service worked closely with the local GP surgery and accessed other health professionals such as the district nurse, speech and language therapist and mental health teams for people when required.

● Prior to the pandemic they worked closely with the local community and primary school. They were keen to build on that once restrictions had lifted and the risks around COVID -19 had reduced.

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 11 HSCA RA Regulations 2014 Need for consent Decision specific mental capacity assessments were not completed for people in relation to all aspects of their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from the risk of abuse.

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 to people were not identified and mitigated, including infection control risks.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance was not established to ensure the service was suitably managed and monitored.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably skilled and trained staff were not provided.

The enforcement action we took:

We served a warning notice.