Hillgay Ltd

Hilgay Care Home

Inspection report

Hilgay
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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Hilgay is a residential care home providing accommodation and personal care for up to 35 older adults living with frailty, dementia and other health related conditions. At the time of the inspection there were 14 people living at the home.

People's experience of using this service:

● There had been significant and continued failings by the provider to improve the quality of care people received following the last inspection. Concerns identified at the last inspection had not been addressed or improved and breaches of regulations remained.
● The service was not well-led, and the provider and management team lacked oversight of the care people received. There had been significant shortfalls in the leadership of the service which had resulted in people experiencing poor quality care.
● People were not protected from the risk of avoidable harm. People were not protected from the risk of abuse. Several incidents of unexplained bruising had not been identified as potential safeguarding concerns by staff, senior staff or the provider.
● People remained at significant risk as identified risks to them had not been safely reduced. Risk management processes were poor and specific risks to people's health such as choking, and skin damage had not been effectively managed, and people had experienced harm.
● Staff told us they did not feel supported in their roles and that there was a poor culture within the home between them and the management team. One member of staff told us, "No leadership, we need that and we're not getting it. We have no one to ask (for support). (Current consultant) is a help, no one else knows anything all locked away in the office."
● Quality assurance processes were ineffective at identifying issues and improvements were not made to the quality of care people received. Concerns identified at the last inspection had not been addressed by the provider.
● Staff did not have access to training to develop their knowledge and to support people safely. The management team were not always assured of staff competency.
● Staff and the management team did not always work effectively with other professionals to ensure people's needs were met in a timely way, specifically relating to raising potential safeguarding concerns.
● People were not always protected from infection control risks. Some people did not have consistent access to hot water in their rooms. People told us that they were unable to wash their hands effectively after going to the toilet during the day because of this. This increased the risk of people experiencing potential ill health.
● People were supported to have maximum control over their lives and staff supported them in the least restrictive way possible.
● Some people were happy with the food provided and had access to regular fluids and snacks.

Rating at last inspection:
Inadequate (The last report was published on 30 March 2019). The rating at this inspection remained Inadequate.

Why we inspected:

This was an unannounced focussed inspection. This inspection looked at the key questions of Safe, Effective and Well Led and to check if the provider had reached compliance with enforcement action issued following the last inspection.

Enforcement:

We found four continued breaches of regulation. The overall rating for this home remains 'Inadequate' and the home is therefore remaining in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. 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.

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

Follow up:

The overall rating for this service remains Inadequate and the service continues to be in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the providers registration, we will re-inspect within six months to check for significant improvements.

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

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 well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Hilgay Care Home

Detailed findings

Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection was completed over two days. On day one two inspectors and an expert by experience visited the home. On day two, two inspectors visited the home. An expert by experience is a person who has experience of using or caring for someone who uses this type of service.

Service and service type:

Hilgay 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 home did not have a manager registered with CQC. The provider had a hands-on role at the home and there were two deputy managers and an interim consultant at the time of the inspection. The provider had advertised for a registered manager.

Notice of inspection:

This inspection was unannounced.

What we did:

Before the inspection:

We contacted the local authority for feedback regarding alleged safeguarding concerns. We reviewed notifications we received from the home about important events. We reviewed information sent to us from other stakeholders for example the local authority and members of the public.

During the inspection:

We spoke with the provider, two deputy managers, the interim consultant, eight members of staff, three relatives and 11 people who lived at the service. We pathway tracked the care of six people. Pathway tracking is where we check that the care detailed in individual plans matches the experience of the person receiving care. We reviewed records including safeguarding concerns, accident and incident logs, quality assurance records, medicines records, policies and procedures and two staff recruitment records.

After the inspection:

We spoke further with the local authority regarding the alleged safeguarding concerns. We requested the provider send us copies of other documents relating to the management of the service. A deputy manager sent us this information as 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 on 8 and 10 January 2019, we asked the provider to act to make improvements to the assessment and management of risks to people, the numbers of staff to support people safely and the systems and processes in place to safeguard people from abuse. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question 'safe' to at least good. At this inspection, this action had not been completed. People continued to be at significant risk due to the provider and management teams' inaction in addressing identified concerns. People continued to not be protected from the potential risk of abuse and staffing levels were not consistent to meet people's needs. Risks to people had not been adequately assessed to reduce these risks to them. There were continued breaches of regulations and compliance with previous enforcement action had not been fully met.

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Using medicines safely.

● Risks to people were not managed safely and people continued to be at significant risk of harm. Some risks to people had been identified but assessments and plans remained ineffective in keeping people safe. When people's needs changed, risk assessments were not reviewed in a timely manner to ensure staff had the right guidance to reduce risks to people. Risks to people associated with eating and drinking were not adequately assessed or managed. For example, one person was assessed as being at risk of choking when eating. Speech and language therapy (SALT) guidance had been given to the management team but this was not reflected in the person's care plan. The person was meant to have a 'soft', 'fork mashable' diet. We observed staff supporting the person to eat food that was not fork mashable. The guidance also stated that the person's fluids should be thickened using a prescribed thickening powder should they cough whilst eating. At lunch time we observed the person to begin coughing during their meal. The meal was not fork mashable and they were given large pieces of chicken. They continued to cough however the member of staff supporting them was unaware of the person's need for thickened fluid to reduce their choking risk. Staff and senior staff told us there was no thickener in the home for the person, nor had there been since the guidance was put in place two weeks prior to the inspection. The management had failed to identify this need and had not ordered this for the person. This meant the person was at significant risk of choking. Once raised with the management team, the thickening powder was ordered, and a safeguarding referral was raised to the local authority during the inspection. We were not confident that had we not highlighted this immediately then this risk would not have been addressed.
● Some people had been assessed at risk of skin damage due to their health conditions. One person was assessed as at significant risk of skin damage and they had experienced several skin tears. These had not been analysed to identify measures to reduce the risk of skin tears to the person. Their care plan and risk assessment provided no guidance to staff to support the person to manage this risk. The person's skin had deteriorated, and a recent skin tear was receiving treatment from the community nursing team as it had

become infected.
Another person had been assessed as at risk of skin damage and professional guidance had been provided to reduce this risk. This guidance was not fully reflected in the persons care records. The guidance stated that they should be supported to reposition every two hours. Records we reviewed showed that this guidance was not consistently followed by staff which increased the potential risk of skin damage to them. The failure to follow professional guidance increased the risk of harm to the person.

● People were not supported consistently if they were at risk of falling. For example, one person had experienced several falls and a sensor mat was put in place. The person became anxious about the mat and staff took the decision to remove it without seeking guidance. Their care plan was not reviewed, and no alternative measures were put in place to protect the person from the risk of falls. They have subsequently fallen on three occasions, and no additional measures have been put in place to reduce the risk to the person.

● The management team had not fully considered risks relating to people's health needs. For example, risk assessments and care plans for people living with diabetes were generic and did not provide staff with the individual guidance to support them should they become unwell. This lack of detailed assessment and no training for staff in this area of care meant that staff were not all aware of how to support people living with diabetes safely. A member of staff told us they were not sure who was living with diabetes and "I don't know much about diabetes". A member of the management team told us they did not think staff would know the signs of ill health for someone living with diabetes.

● Fire risks to people had not been addressed. For example, a fire risk assessment had been completed in January 2018. This identified several actions, two required immediate attention. We found that these had not been acted upon. This meant people were at risk should there be a fire. The provider had been aware of these risks for over a year and had not acted on professional advice to keep people safe.

● Medicines were not always administered safely. Staff were not following safe processes in the administering and dispensing of medicines to people. We observed medicines being administered to people, the member of staff dispensed people's medicines into a pot before asking them if they wanted to take their medicines. For one person, the member of staff carried their medicines around the home, completing other tasks, before administering this to the person. This increased the risk for error during the process of administering medicines.

● The provider had put measures in place to try and improve safety when medicines were being administered, by the staff wearing a tabard, so people and staff knew not to disturb them. However, this was not followed by staff or the person administering medicines. We observed them being constantly interrupted and they completed other tasks such as supporting in the kitchen whilst administering people's medicines. This increased the risk that people would be exposed to medicines errors as staff were not solely focussed on administering people's medicines. There had been medicines errors, one person did not receive their warfarin tablet on two occasions which exposed them to the risk of harm.

● People's medicines records were not always reflective of the medicines people were taking. For example, one person was at risk of skin breakdown and had specialist creams prescribed. One of these creams was not on the person's medicines administration record. This did not provide assurance the person was supported in line with their assessed need. They had experienced subsequent skin breakdown.

People were at significant risk due to the ineffective assessment and management of both individual and fire risks to people. Medicines, care and treatment had not been provided in a safe way. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The member of staff administering medicines was kind and discrete in their approach with people. They ensured people could take their medicines in their preferred way.

Systems and processes to safeguard people from the risk of abuse

● People continued to not be protected from the risk of abuse. At the previous two inspections the provider and management team had not recognised potential signs of abuse or reported these to the local authority. This remained a concern at this inspection, no action had been taken to improve staff, senior staff and the providers understating of abuse.
● During the inspection we found evidence that showed incidents of unexplained bruising for two different people. Staff had documented this on body maps but had not always raised this as a concern. For example, from February to April 2019 a person's care records showed that they had nine separate incidents of unexplained bruising. There was no evidence that any action was taken relating to those bruises including identifying if there were any underlying medical conditions causing people to bruise. The management team had also not identified the potential risk of abuse when reviewing body maps and had not reported these incidents to the local authority. This meant incidents of potential abuse had not been investigated which increased the risk of avoidable harm to people.
● Although staff had a good knowledge of safeguarding and could tell us about potential signs of abuse, this was not always reflected in their practice.

People were not protected from abuse and improper treatment. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staffing and recruitment

● People, their relatives and staff told us there were not enough staff. One person told us, "I sometimes have to wait a long time for staff to help me, I think it is because there aren't enough. Weekends are the worst." A member of staff said, "There is confusion at the moment as rota keeps changing and like today people came in who were not meant to be here as no one knows what they are doing." A relative said, "I don't think there are enough staff-it's like the 'Marie Celeste' some afternoons."
● Staff told us they were not confident in the new rota or the dependency tool and did not feel this allowed them to meet people's needs. Although a dependency tool had been introduced during the week of the inspection, this was not yet embedded in practice nor did it match the staffing levels we observed. For example, the dependency tool showed that there should be four care staff on shift during the day. On the first day of the inspection seven staff were on shift however over the weekend there were two separate shifts where staffing was lower than the assessed levels needed. This had only been identified at the end of the week which increased the risk people would not be supported by the right number of staff over the weekend to maintain their safety. The provider employed the use of agency staff over the weekend.
● Up until recent weeks the home relied on a significant amount of agency staff support. On some shifts more than half the staff were agency and agency staff were leading the team. Permanent and senior staff told us that agency staff did not always know how people wanted to be supported. This meant that staff were being led by senior staff who did not know people or their needs. Agency staff were working together to support people with mobility needs which had resulted in a person becoming injured following a fall from their equipment.
● Peoples call for assistance were not always responded to in a timely way. For example, during the inspection, we went to one person's room who had been incontinent. The person told us, "I need the commode, I have been waiting, I'm sorry." They were distressed about the situation.
● Call bell records reflected this was a consistent issue and in the month of April 2019 there were several instances of people having to wait more than ten minutes for their call bells to be responded to. Eight people had to wait for over 30 minutes. A relative told us, "I think rooms should be checked more frequently. My mother fell over near her wardrobe, she could not reach her bell and I found her on the floor when I came

45 minutes later."

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Recruitment processes ensured staff were suitable to work with people before they started working at the service.

Learning lessons when things go wrong

● Lessons were not learnt when things went wrong which allowed the risk of avoidable harm to continue. There was a significant lack of oversight in relation to accidents and incidents. Accident and Incident forms were completed inconsistently which did not allow for lessons to be learned when things went wrong for people.
● Accidents and incidents were not analysed by the management team to identify themes and trends. For example, care records for one person reflected that they had experienced six skin tears during the months of February to April 2019. There was no analysis of these incidents to identify trends and improve how the person was supported to reduce the risk of skin damage.
●Incidents were not responded to in a timely way to reduce ongoing risks to people. Senior staff told us they could not be assured they were aware of all the incidents of falls as these are not documented consistently and they don't always have time to review them in a timely way due to other priorities. This did not provide assurance that lessons were learnt to reduce the risk of avoidable harm to people.

Systems and processes were not established or operated effectively to ensure that the provider assessed, monitored and improved quality and safety. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were not always protected from infection control risks. For example, 5 people did not have consistent access to hot water due to issues with the boiler system. People were unhappy about this and told us it had been an issue for several months. One person told us they were unable to wash their hands effectively due to not having hot water during the day. They said this made them worry as they could not maintain their hygiene as the would like. This is an area in need of improvement to reduce infection control risks.
●Staff were aware of infection control risks. People lived in a clean and hygienic environment.
● There was a cleaning rota in place and staff used personal protective equipment (PPE) such as gloves appropriately, during the inspection.

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 on 8 and 10 January 2019, we asked the provider to act to make improvements to ensure staff were appropriately trained, supported and were competent to provide effective care to people and to ensure risks to people relating to eating and drinking were identified and reduced. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question 'effective' to at least good. At this inspection, this action had not been completed. Staff continued to feel unsupported and the management team were not assured staff were appropriately trained to meet the range of people's needs. Risks to people relating to eating and drinking remained a significant concern. There were continued breaches of regulations and compliance with pervious enforcement action had not been met.

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

Staff support: induction, training, skills and experience

● Staff were not appropriately trained to meet the range of people's needs. For example,12 members of care staff were working without training in safeguarding. Staff's knowledge of safeguarding was mixed, and we identified several incidents where potential safeguarding concerns had not been identified and raised by staff. This lack of training meant that people were not always being supported by knowledgeable staff. Although the provider arranged for some training courses after the inspection, staff continued to work without the appropriate training to meet people's needs safely.
● Most people told us they thought staff were well trained. One person said, "They look after us well." Our observations identified that staff were not all trained to support people living with specific health related needs such as diabetes and dementia. None of the care staff had received training in diabetes only eight out of 31 staff were trained to support people living with dementia. Professionals had identified that staff lacked experience in supporting people with swallowing difficulties in June 2018 following a possible choking incident and distressing symptoms of coughing for one person. They recommended staff receive training in this area. This was not arranged by the provider until April 2019 and 14 members of staff had not yet received this training, this included a member of staff supporting someone to eat lunch who was at significant risk of choking.
● Competency assessments did not always take place following training, this did not provide assurance that staff were competent within their roles. For example, there was no evidence that medication competency assessments for staff administering medicines had been completed. This coupled with the poor medicines practice observed increased the risk of people continuing to receive their medicines ineffectively.
● There had been a high level of agency staff working at the home. Their competency to use specific equipment was not assessed before they supported people. Although they had a brief induction, the management team confirmed that they were not fully informed of people's care plans, needs and risks. The

management team told us they were not assured of their competency before they worked with people. For example, two agency staff were supporting one person to use their stand aid to transfer. The management team had not assessed their competency in using these aids. The person fell from the equipment and injured themselves. This incident is being investigated by the local authority safeguarding team. The lack of competency assessment for both permanent and agency staff increased the risk that people would not receive care safely or in their preferred way.

● Staff continued to tell us they felt unsupported. One member of staff said, "We don't see the management team, they are around to- day as you are here but normally they are in the office with the door shut and we just get on with things. They never help us and say that they are too busy with paper work." Formal supervision had been introduced in March 2019.

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

● People gave us mixed reviews of the food provided. One person told us, told us "The food is not as good as it used to be." Another said, "I don't think the food is hot enough. "During the lunch meal people commented that the food was nice and a relative told us how the chef gives their relative extra food whenever they liked which ensured they had plenty to eat.

● People were supported to have enough to eat and drink. People had access to drinks and snacks throughout the day.

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

● Health and social care professionals told us they did not always find communication with management and staff effective to meet people's needs. One social care professional told us they had not always been made aware of safeguarding concerns in a timely way and they found communication with the provider difficult. This is an area of practice that requires improvement, so staff and provider communicate effectively other agencies to meet people's needs.

● People had access to healthcare professionals. Records showed that people received visits from district nurses and GP's regularly.

Ensuring consent to care and treatment in line with law and guidance

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

● Staff understood MCA and DoLS. Some people living at the home were subject to restrictions due to their needs. The management team had recognised that people received constant support and supervision and had made appropriate DoLS applications to the local authority. Mental capacity assessments were completed and where people were found to not have capacity to make certain decisions, best interest

meetings had taken place.

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

● The home was adapted to meet people's needs. People could freely access all areas of the home and there was some pictorial signage to help people navigate their way.
● The communal areas were well maintained. There was a large garden which some people were able to access independently. The garden was not accessible to all people without support from staff due to people's needs. Bathrooms were adapted to support people with physical disabilities.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Initial assessments of people's needs and choices had been completed in a holistic way which included their physical health, mental health and social needs.
● Protected characteristics under the Equality Act (2010), such as disability and religion were considered as part of people's initial assessment. This demonstrated that people's diversity was included in the assessment process.

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 on 8 and 10 January 2019, we asked provider to take action to make improvements to the systems and processes in place to ensure good governance and improve the quality of the care people received. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question 'well-led' to at least good. At this inspection, we found this action had not been completed. Significant concerns remained with the leadership and management of the home. There had been no improvements in the oversight and governance of the home since the last inspection. There were continued breaches of regulations and compliance with previous enforcement action had not been met.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The home was not well managed, there were significant shortfalls in the oversight and leadership of the service which led to poor standards of care. There was no registered manager at the home. The provider had stepped down from the registered manager's post following the pervious inspection and was in the process of recruiting a new registered manager. There were two senior members of staff managing the day to day running of the home. We were concerned about the providers and the two senior staff members competency to manage and lead the home due to the significant concerns found during this inspection and the lack of action taken to address concerns found at the previous inspection.
● People and their relatives gave us mixed feedback about the service. Care staff were praised by people and their relatives. One relative told us, "Staff are lovely and fabulous. I see lovely interactions with staff." This was confirmed by our observations of how staff supported people. However, the management of the service was not spoken about positively. A relative told us, "I wouldn't know who the managers are, not introduced. I never see the managers, I wouldn't know who they are."
● Staff told us the home was not well managed and they did not feel supported. Staff felt there was not an open culture and the provider and management team were not accessible. One member of staff told us there was, "No leadership, we need that and we're not getting it. We have no one to ask (for support). (Current consultant) is a help, no one else knows anything all locked away in the office."
● Staff within the management team told us they were not clear on their roles and they felt unsupported. They had received no management training. One of them told us, "We are never supported, we don't know what we are doing or what is expected of us." Another said, "It is very stressful and there is no job

satisfaction."

● The provider and management team had not taken ownership or fulfilled their responsibilities in monitoring and supervising of staff. They had not ensured that people were receiving a safe and effective service and that systems and processes were being adhered to. For example, there was a lack oversight by the provider of the people left in charge in the absence of a registered manager. This meant audits of the service had been inconsistently completed and were not used to drive improvements. Where they were completed, identified issues were not acted upon. For example, three separate medicines audits in March 2019 identified that staff had not received medicine competency assessments. This had still not been actioned at the time of the inspection.

● Quality assurance systems and processes were ineffective in identifying and driving improvements to the service. There was no formal audit of accidents and incidents, potential safeguarding incidents or care plans. The lack of auditing meant that the management team did not have oversight of the care people received and could not demonstrate that they were able to identify trends or recognise potential issues.

● Issues we identified at this inspection had not been identified by the provider. For example, ineffective risk assessing and care planning, safeguarding issues not being identified and people being at continued risk of falls and choking. The management team had recognised some of the issues but had not taken steps to address these as they told us they did not have the time to do everything expected of them.

● Documentation relating to people's care needs were not always up to date or relevant. For example, people had multiple care plans in place for the same need. One person had two mobility assessments in place. One said the person was at high risk of falls at night, the other did not identify this as a concern. There were both reviewed by a member of staff on the same day as being reflective of the person's needs. We found several examples of inconsistent and inaccurate documentation of people's needs. This did not provide assurance that staff understood people's needs or that the guidance in place was reflective of their current assessed needs.

●The provider failed to ensure they promoted consistent person-centred, high quality care and support for people. Care planning was not reflective of people's changing needs and staff told us they do not read care plans as they are not correct. One member of staff told us, "We know how to support them and what they like but we do not write or review support plans. There's no point looking at them as they don't reflect the right things."

●The culture of the service was not supportive of high-quality care. Staff told us morale was low and they were unhappy with the management of the service. One member of staff said, "We are lost souls here we don't know what to do, we don't want to be here, but we love the residents." Another member of staff told us, "The place is awful at the moment, makes me feel physically and utterly ill."

● People and their relatives were not fully engaged in the running of the service. People had limited opportunities to provide feedback on the service they received. Where people had provided feedback, through a survey, there was no evidence this feedback was acted on. For example, a relative had completed a survey and said they were concerned about staffing levels, there was no evidence this had been reviewed or acted upon. The provider told us they had read the response but could not say what they had done to address the concerns.

● People, their relatives and staff all told us they were unaware of the previous inspection report unless they had looked on the CQC website themselves. They told us the concerns had not been shared with them and they did not know what was happening to improve the care people received. A member of staff told us, "Nothing has changed since the CQC report, I was not told about it by managers, I had to read it on line. Nothing has changed since then, I have not seen anything implemented." The also told us they had not been made aware of the report by the provider until it was published, and the enforcement action taken at the last inspection was not shared with them. They said this had affected their ability to make improvements to the service people received. The inaction in being open and honest or involving people and staff in driving

improvements to the home did not provide assurance of the provider's transparency.
● People did not always feel listened to by the management team and the provider. One person was not happy with something during meal time and the member of staff asked them if they would like to make a complaint and the person responded, "It doesn't make any difference if I complain, nothing is done."
● Staff did not feel engaged in the service and they did not feel listened to. A member of staff told us, "The provider is difficult to talk to and engage with. We never see office staff on the floor, they say their priority is paper work and ours is residents. Not really effective so we just get on with what we know we do."

The provider had not ensured that they assessed, monitored or improved the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● Staff did not always work in a timely way with other professionals, or use guidance provided by them to best support people's needs.
● A social care professional expressed concerns about communication with the management team at the home.