Care Quality Commission

Zinnia Healthcare Limited

Yew Tree Manor Nursing and Residential Care Home

Inspection report

Yew Tree Lane
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Manchester
Greater Manchester
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Yew Tree Manor Nursing and Residential Care Home is a care home providing personal and nursing care for up to 43 people aged 65 and over. The home caters for people who may be living with dementia or lack capacity. At the time of our inspection there were 36 people living in the home.

People's experience of using this service and what we found
People's individual risks were not always assessed, monitored and managed effectively. Records of people's dietary requirements, which placed some people at increased risk of choking or aspiration, had not been maintained accurately. Equipment to aid moving and handling of people was not managed safely.

There were numerous risks to people's safety around the home. For example, there were a significant number of trip hazards and a fire exit was blocked. Health and safety records were in place and up to date.

Staff told us the home was often short staffed as staffing numbers had been reduced. This had a negative impact on people's care as staff did not have sufficient time to meet people's needs.

Staff training records were not up to date. It was, therefore, difficult to ascertain whether staff had completed the required training. Incidents were not always recorded and escalated as required.

Staff files were difficult to locate and information was kept in different places. However, the files included appropriate documentation to indicate staff had been recruited safely.

Medicines were not always managed safely. Medicines audits had not been completed for some time, so issues had not been identified and addressed. Thickeners, used when people required their drinks thickened due to choking risks, were not stored safely and were being used communally, for anyone who required them, rather than for the individual for whom they were specifically prescribed. There were no care plans in place for two people who had medicines administered covertly (hidden in food or drink). Senior care staff, who administered medicines, were only required to complete online training and their competence was not regularly re-assessed to ensure their skills continued to be of a good standard.

The premises were not clean, and basic infection control and prevention requirements were not being followed. There was a backlog of laundry and the laundry room had no system to separate clean and soiled items.

There was an appropriate safeguarding policy in place, which staff were aware of. Staff had completed safeguarding training at induction. It was difficult to ascertain whether concerns had been addressed appropriately, as records were not up to date.

People were not treated with dignity and respect. We observed some people waiting a long time to receive personal care. There were two shared rooms within the home. One in particular offered little privacy for the

occupants, as it only had a small portable screen between the beds.

We saw little interaction between staff and people who used the service. Staff did not always have enough information to be able to support people well. There was little evidence to suggest people were asked for their views or involved in decision making around their care and support. 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.

There were a number of incomplete or missing care plans and those that were in place had a lack of detail about people's wishes and preferences. People told us they were not given choices with regard to meals. There was a lack of activities and stimulation within the home.

Although the nominated individual had visited the service in the months leading up to the inspection. They had not taken responsibility for supervising the management of the service or had any effective oversight.

Since the registered manager had left, there had been no system for dealing with correspondence. There were unopened appointment letters for people at the service, which could have had a detrimental effect on their health and well-being

There was no registered manager, deputy manager or clinical lead and no one taking leadership at the home. There was no management oversight, no audits or reviews, had been completed for a number of months. No one at the service had been taking responsibility for submitting notifications to CQC.

The service had not been working effectively with visiting professionals and this had put people at increased risk. This was due to the lack of management and leadership at the home. Complaints had not been monitored for some time.

Staff morale was low and there was currently little engagement from the provider with them. Staff we spoke with said they didn't feel valued.

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 30 April 2020). At this inspection we found the provider was in breach of regulations and the service was rated inadequate.

Why we inspected
The inspection was prompted in part due to concerns received from the local authority, around staffing and the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of 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.

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 Yew Tree Manor Nursing and Residential Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, person-centred care, consent, dignity and respect, premises and equipment and good governance at this inspection.

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

Follow up
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 caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

Yew Tree Manor Nursing and Residential 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
The first day of the inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who worked with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and three relatives. We spoke with fourteen members of staff, including the registered manager and deputy manager from the service's sister home, four nurses, six members of care staff and two agency staff. We also spoke with three visiting health and social care professionals. We spoke with the nominated individual by telephone.

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 observed care throughout the home and observed a full medicines round. We reviewed a range of records, including electronic care plans, several of these in detail. We followed up and cross-referenced a number of records relating to nutrition, hydration, choking risks and skin integrity. We looked at multiple staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• People's individual risks were not always assessed, monitored and managed effectively.
• The provider had failed to assess and manage people's dietary requirements, which placed some people at increased risk of choking or aspiration. Records within care files did not match records held in the kitchen. Six people had errors in their care plans in relation to nutritional needs and choking risks.
• One person had lost a significant amount of weight over the period they had resided at the home. Information about the weight loss had not been escalated as high risk, therefore, the person's food and fluid intake was not being monitored and managed.
• Where people were at risk of skin breakdown, and required regular turning, we found gaps in turning charts. This meant it was not possible to ascertain whether people were being turned regularly, as required.
• Nursing staff we spoke with were unable to explain why there were gaps in the records and were unsure whether people had suffered pressure damage. Two nurses gave us conflicting information about this. One of the nurses told us skin integrity was checked on a weekly basis, but there were no records to verify this was done.
• The service had not taken part in a fire drill for a significant length of time.
• Staff were not sure when to escalate concerns. Incident reports sometimes lacked detail and some incidents were not recorded at all. For example, we witnessed one person having an 'absent episode' where they were found on the floor. Staff said these incidents happened on a regular basis, two to three times per week, but none had been recorded or reported to a health professional to review and monitor.

The provider had failed to ensure people's risks were managed effectively. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

• We found equipment to aid safe moving and handling of people living at the home, was not managed effectively. For example, slings, which were issued to specific individuals, did not have people's names on them and were stored in corridors rather than people's bedrooms.
• On walking around the home, we saw numerous risks to people's safety. For example, there were a significant number of trip hazards, with wheelchairs and walking aids stored inappropriately around the home. One fire exit was blocked and there was a broken gate leading from the garden to an unsafe alleyway.

The provider had failed to ensure the premises were safe and secure. This was a breach of Regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

• Health and safety records were well maintained and the required certificates were in place and up to date.

Fire equipment was regularly checked and serviced.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

• We found the service was not working within the principles of the MCA and if needed, appropriate legal authorisations were not always in place to deprive a person of their liberty.
• Where records indicated people did not have capacity to make certain decisions, no MCA assessments had been completed and we found no records of best interests meetings.
• DoLS applications that required renewal since April 2022 had not been followed up.

The provider had failed to maintain appropriate records regarding people's capacity. They had also failed to provide effective oversight of deprivation of liberty safeguards. This was a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staffing and recruitment
• The local authority had recently taken over the rotas and were making changes to ensure a safe level of staffing. There was a high use of agency staff. Whilst at the home we observed communal areas, on numerous occasions, where there was an absence of staff overseeing people's needs.
• Nursing and care staff we spoke with told us the home was often short staffed and staffing numbers had been reduced. Staff felt this meant they did not have enough time to do all they needed to do to support people. Staff told us agency were regularly used. One staff member said, "[There are] not enough staff. We are struggling with the staff and that is why I am helping in the kitchen. I am a carer and I am preparing the evening meal." Another staff member told us, "Before this [the last two weeks] we were two to three carers short. This meant we couldn't give one to one care properly. People are at risk of falls, not being observed. I have worked as a carer and cleaner, in the laundry and kitchen. There is no chef at the weekends. Carers in the kitchen leave us short."
• Nurses we spoke with told us their numbers had been reduced from two nurses to one nurse during the day shift. This meant they were extremely busy and were unable to ensure care staff were carrying out their duties effectively. One nurse told us, "I don't think it is safe to practice here anymore due to being short staffed."
• A health professional, who was visiting the home, told us, "The nurses are overwhelmed. Staff have reduced from two nurses to one nurse. Case load is heavier. Agency staff increases the risk as they are not aware of people's base line."
• We asked to see rotas for June and July 2022 to look at whether sufficient numbers of staff were on duty throughout this time. Although we asked two nurses and the registered manager from the sister home for these rotas, none were produced.

The provider had failed to ensure sufficient numbers of staff were on duty to ensure people's needs were met. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

• We looked at training records and these were not up to date. It was, therefore, difficult to ascertain whether staff had completed the required training and refresher courses.
• Staff had not received bespoke training to equip them to support individuals with complex and specific health and care needs.
• There were notes of some staff supervision sessions within individual staff files, but we could not find an overview of supervisions. There was no system in place to ensure all staff received regular supervisions and appraisals.

The provider had failed to ensure staff had up to date and relevant training to enable them to carry out their duties. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

• No formal agency induction was carried out, which meant that some agency staff were unaware of their responsibilities. One agency staff member had to be sent home as they were not following good practice requirements in respect of their role. Another agency worker said they had not been shown the fire exits or given an induction, saying "I had no fire induction, building orientation and was not shown any fire exits actually".
• Staff told us some agency staff had a poor command of the English language. One staff member said, "Communication is a problem with some staff [agency carers]. Their accents are hard to understand and some don't speak good English. They don't speak it well enough to work here. If we struggle to understand them, residents won't understand them and that's not fair."

The provider had failed to ensure staff had sufficient guidance and understanding of their responsibilities. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

• Staff files were difficult to locate and information was kept in different places. However, the files included appropriate documentation to indicate staff had been recruited safely.

Using medicines safely
• Medicines were not always managed safely. We found thickeners, used when people required their drinks thickened due to choking risks, were not stored safely. They were kept in an unlocked cupboard in the dining area, where they could pose a risk to people. The thickeners, prescribed for individuals, were being used communally, for anyone who required them. One staff member told us, "I am regular staff and I know people do share the thickeners. One of the nurses told us, "People have their own thickeners. After last week (when it was pointed out by CQC they were all in an unlocked cupboard), they were put in baskets in the kitchen. Staff mess them up. They should be in the kitchen where it is locked when the kitchen staff are not there. The nurse has a key."
• Two people had medicines administered covertly, that was in food or drink. There were no care plans in place regarding the administration of covert medicines.
• Senior care staff, who administered medicines, were only required to complete online training and their competence only assessed on completing their probation period with a nurse. Competence was not reassessed at any time after this, meaning staff skills and abilities may not continue to be up to the required standard.
• Medicines audits had not been completed for some time, so any issues with medicines were not being identified and addressed. We saw one medicine error had not been followed up in a timely way.

The provider had failed to ensure risks with regard to the management of medicines were mitigated. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated

activities) Regulations 2014.

• We observed a medicine round and found the nurse was careful to check all details prior to administering medicines. They ensured people were clear about what they were taking and kept other medicines locked away whilst each administration took place.

Preventing and controlling infection
• On walking around the home we found the premises were not clean, and basic infection control and prevention requirements were not being followed.
• There were no colour coded mop buckets for different areas, as required. Mops were piled together in a corner.
• There was a backlog of laundry and the laundry room had no system to separate clean and soiled items. There was a lack of clean bedding.
• We noticed malodours in many different areas of the home.
• Sluice rooms were extremely dirty.
• There was a lack of available personal protective equipment (PPE) and a lack of hand sanitizer. Agency, domestic staff were not always given a cleaning schedule to follow and were unaware that it was part of their responsibilities to re-stock PPE stations and hand sanitizers when required.
• Staff were not regularly testing for COVID-19. Government guidance states, 'Staff should conduct 2 LFD tests per week, taking them before they begin work, spaced 3 to 4 days apart.' However, staff told us this was not happening. One staff member told us staff decide themselves if they wanted to test or not. Another staff member said, "They tell us what to do. I don't' recall the last time I did a lateral flow test. Maybe two months ago. We used to do it every day." Records of tests were out of date and unclear.

The provider had failed to assess and manage the risk of the spread of infections. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We reviewed visiting arrangements as part of our assessment of infection control practice at the home and found visits were being facilitated.

Safeguarding
• There was an appropriate safeguarding policy in place, which staff were aware of.
• Staff had completed safeguarding training at induction. Two members of care staff felt the training was good quality and were confident about safeguarding issues. However, others were less sure about this subject.
• There was a safeguarding log, where concerns were documented, mainly around altercations between people who used the service. The log had only been completed up to March 2022.
• There were no outcomes following concerns, such as updating care plans, reviewing risks or referring people to GPs for review.

Learning lessons when things go wrong
• There was little evidence the provider learned lessons when things went wrong.
• Accidents and incidents, medicines issues and safeguarding concerns had not been audited recently, so there was no evidence of any learning taken from these issues. However, concerns were now being managed by the local authority.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• Whilst walking around the home on the first day of the inspection we observed some people waiting a long time to receive personal care. For example, one person was asking to be assisted with personal care at approximately 9.45 am. On a further walk round at approximately 11.30 am, this person was still asking to be helped with their personal care. The relative of another person told us they had not had a wash that day, and this was a long-standing problem.
• We observed some mealtimes and noticed people were left with food round their mouths and on their hands. We had to ask staff to attend to this. Some people had their heads on the tables and looked uncomfortable. Staff members asked them if they wished to move, but didn't use any encouragement or persuasion to take them to a more comfortable chair in the lounge, or back to their bedrooms to rest.
• Later in the day we noticed a person being supported in the garden area. They had food stains all down their clothes and on their hands. Although a member of staff was with them, we had to draw their attention to this issue and ask them to attend to the individual's personal care. A staff member we spoke with told us, "The personal care [at the home] is not good. Sometimes I am asked to cut people's hair as we have no hairdresser for example. Yes, people do get showered. Sometimes we don't have shower gel, so we just use warm water."
• One of the shared rooms offered little privacy for the occupants, with a small portable screen being the only method of partitioning one person's area from the other's.
• We noticed one room with no number on it and none of the rooms had a photo on the door to identify them to the occupant of the room.
• Staff told us they often ran out of continence pads. One staff member said, "Sometimes there are no pads, or no wipes and we are using towels. There is no regular ordering." Another staff member told us, "We have had no wipes or pads at times for personal care." During the course of the inspection products were ordered and a system for maintaining stock introduced.

The provider had failed to ensure people were treated with dignity and respect. This was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
• Our observations indicated people were not well treated and supported. We saw little interaction between staff and people who used the service. A regular staff member said, "We struggle to meet people's needs as we don't have enough time. We often have no time to speak with people."

• We saw people, on occasions, asking for assistance and not being attended to due to staff being busy. However, one person said, "Yes, I feel safe and they look after me alright." A relative said, "[Person] is well looked after, I am getting to know staff and staff are getting to know me."
• Staff did not always have enough information to be able to support people well. One agency staff member told us, "I am covering one to one whilst the other staff member is on a break. I don't have any information about why [person] is on one to one. I am just looking at [person's] care plan to find out." The staff member was struggling to read the information whilst supporting the person, who was clearly agitated and restless.

Supporting people to express their views and be involved in making decisions about their care
• There was little evidence to suggest people were asked for their views or involved in decision making around their care and support.
• We saw some out of date audits around the dining experience. The mealtime had been observed and people's opinions had been sought afterwards. Some issues had been identified within the audits but it was unclear whether any actions had been taken to address the issues.
• The provider, on their occasional visits to the service, spoke with people to ascertain their satisfaction with their care.
• Care plans did not evidence involvement with people or their relatives around care and support. One relative we spoke with told us, "I have had no involvement in care or reviews."

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• There was a lack of activities and stimulation within the home. We did not see any activities taking place within the three days we were on site. When asked about activities people told us, "No, there is nothing to do. I don't know what we do", and, "I like the peace and quiet, I relax and watch tv. I don't want to join in things, I want to be peaceful." A staff member told us, "People living here don't have enough to do. We have an activities person for a couple of days, but we used to have two. If we had time, we would do activities, but we have no time, because we are always short staffed and staff are leaving. We used to sit with people and have a coffee and chat, but we can't do that now."
• There were a number of incomplete or missing care plans and many of those that were in place lacked detail about people's wishes and preferences. Staff told us they were aware of people's needs from speaking with the nurses or reading summary notes.
• There was a menu on the wall, which indicated people had a choice of food every day. We observed people eating a variety of breakfasts. However, some people told us they were not given any choice with other meals. One person said, "Very good food, what is given is alright. No, there is no choice." Another person told us, "Food is OK. There is no choice, it comes on a plate but everything is nice."

The provider had failed to offer person-centred, inclusive care for people. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• We found the nominated individual had not taken responsibility for supervising the management of the service and, therefore, were unaware of issues affecting the well-being of people.
• Since the registered manager had left, there had been no system for dealing with correspondence. There were unopened appointment letters, from up to two months previously, found for people. This could have had a serious detrimental effect on people's health and well-being.

The nominated individual had failed to take responsibility for supervision of the management of the service. This was a breach of Regulation 6 (Requirement where the service provider is a body other than a partnership) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Continuous learning and improving care

• There had been no registered manager, deputy manager or clinical lead at the service for some time, and no one taking leadership at the home. No management oversight, for example audits and reviews, had not been completed at the service for a number of months.
• We looked at electronic and paper records of audits and all were months out of date. This meant there had been no system in place to identify issues or concerns and address them with appropriate actions.
• We were unable to find overviews of areas such as weights, pressure areas and falls. This meant patterns and trends could not be identified and addressed.
• Due to the lack of oversight and management systems, the issues with missing, inaccurate and incomplete care plans had not been picked up.
• There were a significant number of inaccurate and incorrect records relating to nutrition, hydration and skin integrity. Choking risks had not been accurately documented so that appropriate mitigation could be implemented. This meant people may not be receiving the correct level of care and support and left people at risk of serious harm.

The provider had failed to ensure systems were in place to monitor and improve the quality and safety of the service. The provider had also failed to maintain accurate, complete and contemporaneous records in respect of each service user. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Working in partnership with others
• The service was visited regularly by health and social care professionals. Those we spoke with raised concerns about the care and support provided at the home.

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 demonstrated little understanding of their duty of candour.
• Complaints had not been monitored for some time, so may not have been responded to in a timely way.
• Notifications, required by CQC, regarding issues such as deaths, serious injuries and allegations of abuse, had not been submitted, following the departure of the manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Engagement with people who used the service, and their relatives, was limited. There was little evidence within care plans to demonstrate people had been involved in decisions around their care and support.
• Where people lacked capacity, there was no evidence of best interests meetings taking place to ensure issues such as care and treatment and covert medicines were being provided in their best interests.
• Engagement with staff was poor and we found morale amongst staff was low. One member of care staff, when asked if they felt valued, said, "The management don't' care here. I do not feel valued." A second staff member told us, "The management has been really poor. We have no support. I had my first break today at 4pm and I started at 8am." A third member of staff commented, "No, the management don't care about the staff. We need support and leadership. We need someone to say thank you for our hard work."