R Beeharry

Fitzroy Lodge

Inspection report

2-4 Windsor Road
Worthing
West Sussex
BN11 2LX

Tel: 01903233798

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Fitzroy Lodge is a residential care home providing accommodation and personal care for up to 24 people in one adapted building. The service provides support for people living with a range of health care needs, including people living with dementia. There were 15 people living at the home on the first day of our inspection, this had reduced to 11 people on the third day of our inspection because some people had moved to other services.

People's experience of using this service and what we found
There were wide spread concerns about the quality and safety of the service. People were at risk of abuse and neglect. Staff did not recognise or respond appropriately to signs of potential abuse. We raised safeguarding alerts for people with the local authority who took immediate action to make people safe and a police investigation began.

There were widespread failings in the management of the service. The provider did not have effective systems in place to ensure they retained oversight of the service and this had allowed a closed culture to develop. We took urgent action to impose conditions on the provider's registration to address management issues.

Risks to people were not always assessed and monitored effectively and people were at risk of harm. Some people were at risk of choking but were not receiving the support they needed. Risk assessments and care plans were not comprehensive. Some people had health conditions and the impact and associated risks had not been considered. This meant that staff did not have all the information they needed to provide safe, effective care in a personalised way. The provider was relying on the use of agency staff who did not know people well, this increased the risks to people. There were not always enough suitable staff deployed to support people's needs.

Systems for managing medicines were not effective. There were not always staff on duty who were trained and competent to administer medicines. Records relating to medicine administration and disposal of medicines were not accurate. This meant the provider was not able to account for some medicines. People were prescribed creams for skin conditions, but these were not being consistently applied and some people had developed sore and itchy skin as a result.

Infection prevention and control measures were not effectively managed. Staff were not clear about testing arrangements for COVID 19 and the lack of records meant that the provider could not be assured that tests had been completed consistently. There was no system in place to check the COVID status of staff before they came into contact with people and other staff in the building. The poor condition of the environment throughout the property meant that it was difficult to ensure cleanliness was maintained.

People were not always receiving the support they needed with food and drinks. Several people had

unplanned weight loss but there was no record of actions taken to address these concerns. Record keeping was inconsistent, and this meant the provider could not be assured that people were receiving the food and fluids they needed. The quality of food was poor with mainly frozen food and a lack of fresh fruit and vegetables.

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 good practice. Some people had conditions placed on their authorisation to deprive them of their liberty. There was no system in place to ensure these conditions were met and staff did not know or understand their responsibilities to comply with these conditions. Records did not identify that people had consented to restrictions or how decisions were made in people's best interest if they lacked capacity.

Most people and relatives said staff were caring and they liked them. However, some people told us staff were not always kind to them. A person told us how a staff member, "Told them off," and described them as being unpredictable saying, "They are alright sometimes, if they are in a good mood." A relative raised concerns about how staff spoke to people and to them. Not all staff knew people well and some staff did not support people's dignity. The language used in daily records suggested a culture where people were not always respected, and their needs were not well understood.

People were not receiving care and support in a personalised way. Staff did not know people well and care plans did not provide enough detail to enable staff to care for people in a personalised way. Staff were not always responsive to changes in people's needs. There were few opportunities for social stimulation. One person told us they spent their time waiting for their family to visit. Complaints from people or their relatives were not always recorded and addressed.

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 1 October 2021). 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. The rating for the service has deteriorated to inadequate.

Why we inspected
The inspection was prompted due to concerns received in relation to safeguarding people, and the management of the home. A decision was made for us to inspect and examine those risks. 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.

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 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 multiple breaches at this inspection in relation to people's safety and well-being, management of risks, food and drink, seeking consent, staffing, treating people with dignity and respect and the management and oversight of the service. We took urgent action to ensure people's safety.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Fitzroy 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
Five inspectors completed this inspection over three days.

Service and service type
Fitzroy 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 not present during the inspection. The provider had arranged for someone to be in charge of the day to day running of the service in the absence of the registered manager. In this report we refer to them as the "person in charge".

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and four relatives about their experience of the care provided. We spoke with 11 members of staff including the provider, the person in charge, care workers, the chef, the domestic and a volunteer. 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 a range of records. This included 12 people's care records and multiple medication records. We looked at 14 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We received information from social care professionals working with people who live at the service, a pharmacist who had regular contact with the service and the Fire and Rescue Service who completed an audit during the inspection. We took urgent action requiring the provider to make immediate improvements and assurances were sought about the safety of the service.

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.

Systems and processes to safeguard people from the risk of abuse

- Systems were not effective in identifying and preventing abuse. People had experienced bullying, discrimination, physical abuse and neglect. Staff had failed to recognise and report abuse.
- We received a video showing potential abuse of people and raised a safeguarding alert with the local authority. Allegations of abuse were reported to the police.
- Some people told us they did not feel safe and described improper practice by staff. One person told us how a staff member would get really annoyed with them, they expressed feeling upset and worried. They also described feeling anxious about staff treatment of another person living at the service and explained, "They don't do what they are told and that drives them (staff) mad."
- A relative told us they had concerns about the attitude of some staff. They described how a staff member had been rude and aggressive when they reported concerns to them. They expressed feeling worried about their loved one and other people living at the service.
- Most staff had received training in safeguarding people but were not consistent in their understanding of what constitutes abuse. Staff had failed to recognise and report when people were being abused. This meant that people had not been kept safe and alleged abuse had not been reported in line with the provider's policy and local safeguarding arrangements.
- Incidents that could indicate potential abuse, including unexplained bruising, had not been identified and reported in line with the provider's policy and local safeguarding arrangements.

This meant that people had been exposed to abuse and 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.

Using medicines safely

At the last inspection, medicines were not always managed safely and there was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider sent an action plan detailing what they would do to make improvements.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Medicines were not received, stored, administered and disposed of safely and medicine practice remained unsafe.
- There were times when staff on duty were not trained and assessed as competent to administer medicines

safely. A person in charge told us they were the only person administering medicines each day to ensure there were no errors. They also told us they did not attend the care home at night because nobody was prescribed night-time medicines. People's medicine records showed some people had prescribed medicines to be administered when required (PRN) including pain relief medicines. People could not be assured of always having access to their prescribed PRN medicines during the night, because there was not always a staff member trained to administer them.

● PRN protocols were not always in place or detailed to ensure medicines were administered safely and as intended by the prescriber. There was a lack of information to guide staff about when medicines should be offered or any specific information such as the person's capacity to request or refuse medicines, how to recognise a person maybe in pain or if any alternative therapy needed to be considered first. For example, one person had been prescribed PRN medicine to help them sleep. Medicine administration records (MAR) recorded this had been administered regularly. There was no evidence this had been reviewed by a doctor or the reason for its regular use explored. There was a risk PRN medicines and their effects were not being monitored effectively because there was a failure to record if administered medicine had been effective. This had the potential to cause harm and avoidable discomfort to the person.

● Some medicines had been handwritten on the MAR's. Best practice guidance from the National Institute for Health and Care Excellence (NICE) states that when medicines are transcribed in this way they should be checked and signed by two staff members as correct. There was a failure to follow best practice guidance. MAR records showed a failure to sign hand-written, transcribed medicines to show who had added them. For example, one person's MAR had pain relief medicine prescribed twice a day. This had been crossed through and changed to four times a day. 'PRN' had also been added to this entry. There was no information to show who had authorised or made these changes and why they were required. Medicine audits dated July and August 2021 recorded handwritten entries were clearly written, dated, signed and counter signed. This had not happened. This meant the oversight of medicine administration was ineffective and inaccurate and the provider could not be assured people were receiving their medicine safely and in line with the prescriber's instructions.

● Some people had been prescribed topical body creams. There was information in the MARs to inform staff to refer to the topical MAR's in people's bedrooms. There were no guidance to inform staff where to apply topical body creams. We observed that some people had dry skin and they were complaining of feeling itchy and sore, there was no system in place for recording when prescribed creams had been applied. This meant the provider could not be assured that people were receiving their prescribed creams consistently.

● On the third day of inspection charts for recording application of creams were in place, however these were not all accurate. For example, one person had three types of cream in their room, but their MAR listed only one cream which was different to those in their room. Care records showed the person was self - administering the cream twice a day but their skin appeared to be dry and flaky and not well moisturised. The person told us they did not use creams and the prescribed cream listed on the record chart could not be found. This meant that we were not assured that people were receiving their prescribed creams consistently.

● Medicine storage was not safe. The downstairs medicine cupboard contained a pot of cream used to help maintain good skin integrity. This did not have a person's name on it. The pot of cream had been half used; the person in charge told us this was used 'for staff purposes.' There were three tubes of an antifungal cream, these did not have people's names on them. There was a tube of cream which had been prescribed for a person, however, their name and details had been scribbled out. This left people at risk of receiving skin creams that had not been prescribed for them or had been used by other people.

● Systems for receiving, storage and disposal of medicines were not robust. When medicines were received at the service, staff had not signed to say they had been received, or how many. Most medicines were in blister packs. Blister packs are a device designed to contain individual doses of medicines in separate compartments or blisters, for different days and times. However, some medicines were also provided in original boxes. These had not been checked to confirm the correct amount had been received. For

medicines not in blister packers there was no system to monitor stock levels to determine if the correct amount of medicines had been given.
● There were several locked medicine trolleys throughout the home. We asked the person in charge about these. We were told they were empty and no longer in use. Due to our concerns about medicines management we asked for them to be opened. In one of these medicine trolleys there were antibiotics, an inhaler and a laxative medicine. We found one cupboard that contained medicines prescribed for a person's end of life care. The person in charge told us that these needed to be returned to the pharmacy. There was no evidence of a safe disposal system for medicines.
● On the third day of the inspection the person in charge told us that all the medicines that we had previously seen in unused medicines trolleys had been returned to the pharmacy. A system for recording medicines for return had been put in place with signatures to confirm they were returned to the pharmacy. However, several medicines were listed without a signature. The provider was not able to tell us what had happened to these medicines and we could not verify whether they had been received by the pharmacist for disposal. This meant that there were a significant number of medicines that were not accounted for.

The lack of effective systems to manage medicines safely meant there was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made. Medicines were dispensed individually and given to people. The medicine administration records (MAR's) were only signed once people had taken their medicines.

Preventing and controlling infection
At the last inspection, improvements were needed to ensure people were protected from the risk of infection and there was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider sent an action plan detailing what they would do to make improvements.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12
● We were not assured that the provider was admitting people safely to the service.
At the last inspection improvements were needed to ensure people were safely admitted to the service. At this inspection the person-in-charge told us there was no admission procedure, related to COVID-19 as there had not been any admissions since the start of the pandemic. However, statutory notifications submitted to CQC showed that two people had been admitted to the service since the last inspection in July 2021. This meant we were not assured that the provider had systems in place for admitting people safely to the service
● We were not assured that there was a consistent system in place for accessing COVID-19 testing for people using the service and staff. The provider told us that people and staff were tested in line with government guidance. An undated infection prevention and control (IPC) audit recorded this was happening. However, there was no evidence to verify when tests had been taken, or the results. The provider was unaware of any records being completed to evidence this, for example lateral flow device (LFD) were not registered consistently when completed. Information provided to us by the local authority, showed polymerase chain reaction test (PCR) for people and staff had been completed, but there remained no system to provide monitoring or management oversight of testing at the service.
● We observed that not all staff were familiar with taking LFD' tests and did not understand the need to wait for the test to develop and to log the result. One staff member was seen to undertake an LFD test but did not wait for the result to develop and continued into the service before anyone had checked the result of their test. Another staff member was assisted by a colleague to complete an LFD test and was supported to log a

negative result before the test had time to develop. They told us, "I don't usually have to do this, it's because you are here today."

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The housekeeper worked 20 hours a week over 5 days. There was no cleaning staff at the weekend. There was no cleaning schedule or records to show cleaning had taken place. Staff told us only essential cleaning, such as toilets took place at weekends. Items for washing were transported to the laundry in the laundry trolley. We asked staff if they used the red bag system to wash soiled linen separately. We were told items for washing were brought into the laundry and then sorted into red bags. This meant there was a risk of cross-contamination from soiled and non-soiled items.

● We were not assured that the provider's infection prevention and control policy was up to date. We asked the provider for a copy of their infection control policy during the inspection, however this was not in place. COVID-19 risk assessments had been completed for people. These generated a score but there was no information about what the score meant or whether any actions were required.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Visitors to the home were given an LFD test to complete and waited in the conservatory for the results before they were able to see their relative. Relatives told us this always happened. Visits were by appointment and took place in the conservatory away from the main home. An activities person visited the home. The provider told us they had checked their COVID-19 pass to ensure they were fully vaccinated, and their LFD was negative. However, none of this information was recorded therefore we were unable to confirm if this did happen with each visitor.

● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely. There was enough PPE at the service. Staff were seen to be wearing this. We did observe an agency staff worker wearing their mask underneath their chin which was feedback so it could be immediate rectified. People appeared comfortable with staff wearing masks.

● We were somewhat assured that the provider was making sure infection outbreaks could be effectively prevented or managed. There had not been any COVID-19 outbreaks at the home. Staff told us they had received training about how to put on and take off their PPE. There was plenty of PPE, hand gel and handwash available throughout the home. Only staff who were vaccinated worked at the service. Until recently there had been a stable staff team however there was a current reliance on agency staff. The provider told us information about staff COVID-19 vaccination status and negative testing had been received before the person commenced each shift. However, there was no evidence to support this.

● In addition to IPC concerns related to COVID-19, we also identified other IPC concerns. We were not assured that sufficient time was allocated to ensure the service was cleaned appropriately. Although the housekeeper worked hard during their time at work there was not enough time to address all the cleaning required. Some areas were not clean including shower trays and toilets that we were told were in use. There were tiles missing from bathroom walls and around shower fittings. This meant that these areas could not be fully cleaned to prevent the risk of cross-contamination from infection.

● There was a cat feeding bowl and water bowl in the dining area. We were told the cat was no longer around, however the feeding and water bowl had not been removed as this may distress people. Both bowls were dirty with what appeared to be old food and limescale. This was not hygienic and ran the risk of carrying and transmitting iinfection.

● In one person's bedroom we observed a pressure relieving foam mattress. This smelt very strongly of urine that suggested it had not been cleaned for a long time.

● The arms on some dining room chairs that people were using, were sticky and had not been cleaned properly.

The failure to have safe systems in place for infection prevention and control meant that there 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 assured that the provider was meeting shielding and social distancing rules. Due to the nature of their dementia some people were not able to understand the concept of social distancing from each other or from staff. There was enough space at the home for the number of people, at the time of the inspection, to spend time apart in different areas of the home.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Visitors were able to visit their relatives when they wished. We saw one person's visitors during the inspection and heard staff telling another person when their relative was due to visit them. There was an appointment system and people met with their visitors in the conservatory and not in the main house. One person told us they had enjoyed trips out with their family and to church. This person told us that when they were in communal areas such as shops and church they wore a mask to protect themselves and others.

Staffing and recruitment
At the last inspection, staff were not always recruited safely, this was a breach of regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider sent an action plan detailing what they would do to make improvements.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19
● Staff were not always recruited safely, and checks were not consistent to ensure that staff had the skills, competence and experience to meet people's needs. This placed people at potential risk of harm.
● One staff member had previously been employed by the provider but had left in 2018. They explained how they had recently come back to work at the service. There was no recruitment information for this staff member and no recent recruitment checks had been undertaken. The person in charge said this was because they knew the staff member from working there previously. This meant people could not be assured that staff who were supporting them were safe to do so.
●The provider was using agency staff to cover for several vacancies. The provider received profiles from the agency to check that staff had the skills and experience they needed to care for people safely. However, there was not a consistent system and record to ensure that profiles were always received and checked before agency staff started work. This meant that the provider could not be assured that staff had the competence, skills and experience they needed to provide safe care and meet people's needs.

The failure to have adequate systems to check the suitability of staff put people at risk and is a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

●There were not always enough suitable staff deployed to meet people's needs.
●There had been a recent significant reduction in staff availability as a result of actions taken to safeguard people.
●Some people needed support and encouragement at meal- times, but staff were not always available to provide the support they needed. For example, one person was observed eating a sandwich at breakfast time, there were no staff around for twenty minutes. The person's care plan identified that they needed support with eating and drinking due to a visual impairment and for their safety they should not be left alone.
●People told us they felt staff were too busy to spend time with them. One person said, "I don't like to disturb the staff when they are so busy." Another person told us, "I don't think they have enough staff at the moment."

● The person in charge and the provider described the staffing difficulties they had. They explained they were not able to confirm staffing levels in advance because they were reliant on support from agency staff that could not be guaranteed. They described how permanent staff were being flexible to enable adequate cover with the use of agency staff. The provider told us of plans to recruit permanent staff. We have commented further on the provider's lack of systems to ensure that there were sufficient suitable staff in the well led domain of this report.

The lack of sufficient, suitable staff to ensure people's needs were met was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people were not always managed effectively. This meant that people were at significant risk of avoidable harm.
● The person in charge told us that everyone was able to eat and drink independently and did not need support from staff. However of concern was that, records showed that some people were assessed as being at risk of choking. Our observations identified that people were not always receiving the support they needed with eating and drinking.
● We observed that there were no staff present in the lounge area when people were eating their evening meal. One person was observed to be using their hands to eat their food and was coughing when eating, they had no drink near them and there was no staff member in the room to supervise or offer support for more than fifteen minutes. A choking risk assessment had been completed for the person and identified that they were at high risk of choking following a previous incident. There was no guidance for staff in what actions to take if the person began to choke and staff had not received training in what to do if someone was choking. The risk assessment and care plan guided staff to provide support and supervision with eating and drinking. This guidance was not being followed, staff were not always present and this put the person at increased risk of harm.
● Another person was assessed as being at risk of choking. Their care plan and risk assessment contained conflicting information. This meant that staff did not have clear guidance on how to provide consistent safe food and support. Observations during the inspection showed that staff were not following guidance to provide mealtime support in accordance with the person's care plan. This put the person at increased risk of harm.
● Information about risks of choking were not communicated to staff who needed to know, including the chef and staff members who were supporting people at mealtimes. For example, a visiting social care professional told us that they had witnessed a person taking chocolate from a bowl placed near them and then having a choking incident with no staff present to support them. This meant the person had been placed at increased risk of harm because important information to keep them safe had not been shared or implemented.
● Safety concerns and incidents were not consistently reviewed, and improvements were not made when things went wrong.
● Systems for recording incidents and accidents did not provide sufficient information to give the provider assurances that risks were well managed. For example, some records recorded falls were unwitnessed, or the cause of injuries were unknown. Some body maps had been completed, but these did not contain adequate detail, to show what actions were taken or follow up measures needed following accidents or injuries. No evidence was recorded to show that staff had looked into possible causes or taken any actions to identify and mitigate risks.
● People who were assessed as being at risk of falls were not always supported in line with their risk assessment and care plans. Records showed that one person had been found at the top of the stairs after having an unwitnessed fall. Their care plan identified that they needed support from staff when mobilising

due to being at high risk of falls, however records showed they had been walking alone with their walking frame when they fell. The person had suffered a head injury and paramedics were called but there was no record to show what actions staff took to monitor them following the head injury. There had been no changes made to their falls risk assessment or care plan following this incident to show what action had been taken to improve safety and avoid further falls.

● Another person was assessed as being at risk of falls. They had been diagnosed with visual and auditory sensory loss; their admission information included that they were registered blind. These risks had not been included within the mobility or falls risk assessments and consideration had not been given to the impact this had on the risks of falls or how to support them when moving around.

● Environmental risks were not safely managed. On two occasions we found an unlocked cupboard of products considered hazardous to health (CoSHH) open.. People at the home with living with dementia and may not be aware of what the products were. These would be extremely harmful if consumed.

● Risks in relation to the safe use of stairs had not been identified. Records showed two people had fallen on or near the stairs, but there was no information about any steps taken to mitigate further risks.

The failure to manage risks to people was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 8 May 2018 this key question was rated as good. At this inspection this key question has now deteriorated to inadequate This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- Assessments of people's needs were not comprehensive, lacked detail and sometimes included conflicting information that did not provide clear guidance for staff.
- People's health conditions were not consistently considered, and associated risks were not always assessed. This meant staff did not have all the information they needed to understand the level of risks for people and to provide safe and effective care. For example, a person who was diagnosed with epilepsy had no risk assessment to determine the impact this had and what support they needed to manage the condition.
- Records showed that one person had a diagnosis of diabetes which was controlled by diet. Risks associated with diabetes had not been identified and there was no guidance for staff about how to support the person to manage their diabetes or to recognise the signs of unstable blood sugars or the action to take. The person in charge had not been aware the person was diabetic and there was no information or guidance provided to staff who needed to know this, including the chef and care staff. This put the person at risk of harm.
- There was a lack of effective risk assessments in place. For example, care plans identified that people needed support to maintain their skin integrity but did not identify the level of risk. National Institute for Health and Care Excellence (NICE) guidance identifies the importance of identifying individual risk factors that could increase a person's risk of developing a pressure sore. No evidence-based risk assessment tools had been used to identify the level of risk for people. This meant that staff did not have all the information they needed to provide effective care.
- Some people had risks associated with their mobility and needed support with moving around. Manual movement risk assessments had not been completed consistently to identify the level of risk and provide staff with clear guidance. Some care plans identified that people needed help from one or two staff members but did not specify the circumstances that would determine this. There was no information to guide staff in when a person needed one staff member and when they needed two. Another care plan identified that a person was at risk of falls but there was no assessment to determine the level of risk. The care plan identified that they could mobilise independently, but another part of the care plan identified the person needed support from a staff member, this inconsistent information meant that staff did not have clear guidance in how to support the person and meet their needs. This meant that people were at risk of not receiving effective care and support.

The failure to undertake assessments and provide clear plans for managing risks to people was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not always provided with the support they needed at mealtimes, options were limited and food was not always appropriate to meet people's dietary needs.

● People told us there were limited options available at mealtimes. One person told us they were not offered a choice and usually didn't know what the meal was until it was brought to them. They said, "If we ask, the staff tell us, but no, we don't get a choice." Another person said, "Food is fine, perfectly cooked, we are not given choices, the food is given to us." We asked what happened if they did not like or want the meal provided. A person told us they could ask for another option, usually a sandwich or toast.

● Information about people's dietary needs and preferences were not always passed to the chef. A list of dietary needs identified that some people were vegetarian, some people were diabetic, and others needed a soft diet. However not every person was included on the list and some information was not accurate or was missing. For example, two people who were diabetic did not appear on the list, a staff member said that the list needed to be updated.

● A person was diagnosed with diverticulosis. There was no information in their care plan to assess risks associated with this condition or identify dietary requirements to support them to manage this condition. NICE guidance recommends that people with diverticulosis, receive a healthy balanced diet, high in fresh fruit, vegetables and whole grains and adequate fluids and a high fibre diet are important. We observed that people did not have access to fresh fruit and vegetables, and meals we observed included frozen or tinned vegetables. Staff were not aware that this person had this condition and no actions had been included to inform staff how best to monitor and manage this condition.

● Staff did not all know people and their dietary needs and preferences well. Some agency staff told us they were not aware of people's needs and the information provided to the chef was not accurate. For example, some people were not listed on the chef's chart for identifying dietary requirements, this included a person who was diabetic. This increased risks that people's dietary needs would not be met.

● Staff were monitoring people's weight regularly and records showed that some people had unplanned weight loss. There was no record to show what action had been taken to determine why people had lost weight or that they had been referred to an appropriate health care professional. This meant that risks of malnutrition were not being assessed and managed.

● Staff were recording food and fluids provided but these records were not always accurate. We noted that records of care provided at night identified one person had received a good fluid intake. However, their fluids chart showed that they had not had any fluids between 9pm and 7am. Fluid charts did not include a total amount and there was no target amount included. This meant that staff could not be sure if people had received the amount of fluids that they needed on a daily basis. One person had been admitted to hospital just before the first day of inspection and had been diagnosed with dehydration. The poor standard of record keeping, and lack of relevant risk assessments and care plans meant that the provider could not be assured that people were receiving the support they needed with food and drinks.

The failure to provide people with adequate support with food and fluids was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●The decoration and design of the home did not improve people's quality of life or promote their wellbeing.

● Some areas of the property were in poor repair. Not all bedrooms had hot running water available. People told us this was not unusual and that the central heating was also not reliable. During the inspection the provider had arranged for a heating engineer to attend to the boiler, this had improved the central heating, but some rooms remained without hot water. One person told us, "I had hot water this morning but sometimes I have a cold wash."

● A downstairs shower room was very cold, and the shower was leaking and coming away from the fixing to the wall. A member of staff confirmed that this shower room was used to support people with personal care.

● Wall tiles were missing in several rooms, the flooring throughout the home was in poor condition, including threadbare carpet upstairs and worn laminate flooring downstairs. A carpeted slope on the first floor corridor had no guard to one side. There was no risk assessment in place to identify and address the risk of falls that this presented.
● One person's bedroom was well personalised and comfortable, they told us they were proud of the room and had enjoyed making it nice and homely. We did not see any other rooms decorated to this standard. Most rooms were not well personalised, sparsely furnished with old furnishings and décor. For example, in the dining area chair arms were loose and came off when people leaned on them.
● The provider told us they had plans for refurbishment including new flooring throughout the home.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were not consistently supported with their health and well- being.
● Where people's health needs were being monitored, staff were not consistent in acting on issues identified. For example, three people were identified to have unplanned weight loss. Staff had contacted the GP with regard to one person. The GP recommended a fortified drink, but this had not been implemented and their weight had continued to decline. The other two people had not received evaluation or support with their unplanned weight loss. This meant that people were at risk of their health deteriorating.
● Recommendations for care and treatment from professionals were not consistently followed. People were not always provided with the support they needed with food and drinks or with their personal care needs.
● People were not always supported to access the health care services they needed. One person was diagnosed with diabetes and needed an annual diabetes eye check. Their appointment had been cancelled but there was no explanation about why or whether another appointment had been arranged. This meant the person was at risk of a deteriorating health condition.
Failure to support people to manage their health and well-being was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● The person in charge described a positive relationship with the GP.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff did not demonstrate a clear understanding of their responsibilities under MCA. The person in charge and some staff spoke about people as not having capacity in a generalised way. Care records did not identify where people had been assessed as lacking capacity to make specific decisions. For example, people had sensor mats in their bedrooms to alert staff when they got out of bed. Staff told us this was so they could support people with their mobility. There were no records to demonstrate whether people had

consented to have pressure mats in place and no records to identify how a decision had been made that was in their best interests if people were judged not to have capacity to make this decision.
● One person had a DoLS authorisation with conditions attached that they must be supported to access the local community as regularly as possible, including walks on the seafront, to the local shops and other areas of interest. The condition stated that a record of all outings must be kept but there was no record and staff were not able to tell us when the person had last been out in accordance with this condition.

The failure to comply with a condition imposed on a DoLS 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.

Staff support: induction, training, skills and experience
● Staff had not received consistent support, training and induction to ensure they had the skills to be effective in their roles.
● The provider was not able to supply an up to date list of training and supervisions that staff had received. Some training certificates were sampled and showed that some staff had received recent training in a range of subjects relevant for their role, including manual handling, dementia, safeguarding, food hygiene, infection control and first aid.
● The person in charge told us that all staff had received training in safeguarding people. Staff we spoke with did not all demonstrate a clear understanding of their responsibilities with regard to safeguarding people, they were not sure when, how or to whom they should report any concerns.
● Staff were not all receiving regular supervision. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Records showed that some staff had received supervision, the most recent record was dated April 2021 but other staff had not received any supervision, including one person what was new to their role.
● Not all staff had received a comprehensive induction for their role. One staff member told us they had completed some online training and had shadowed experienced staff to support their understanding of providing personal care. We observed they appeared to lack confidence, particularly when interacting with people and supporting people at mealtime.
The failure to ensure that staff had the training and support they needed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

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

At the last inspection 8 May 2018 this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- People had not always been treated with kindness and respect. We received information of concern that people were not being treated with dignity and respect.
- People and a relative told us about how some staff were not always kind and caring. One person described how a staff member had got annoyed with them and they had been "told off." They described feeling that the staff member's behaviour was unpredictable, saying, "They are ok when they are in a good mood." A relative described how they had experienced some staff to be rude when they visited their relation and described feeling concerned for their relation due to the attitude of some staff members. These concerns were raised with the local authority safeguarding team.
- Records of care provided to people did not support a person-centred culture. The language used to describe people was not always kind or respectful. For example, daily records described how a person was displaying signs of being distressed. Records consistently referred to them being "demanding," "annoying" "pestering" and "harassing staff." This did not demonstrate an understanding of the person's needs or a kind and compassionate approach.
- Our observations were that whilst some staff had developed positive relationships with people and knew them well, not all staff demonstrated an understanding of the needs of people with dementia, including when they were distressed. Some staff were task focussed and did not interact with people to provide support in a caring and compassionate way. We observed a staff member serving a meal to people in the lounge area, they had very little interaction with people. The staff member handed the dessert and a spoon to each person in turn, they did not tell people what it was or ask if they wanted anything else of if they had everything they needed. The staff member was seen supporting a person to eat their dessert, but they stood in front of the person and offered food on a spoon without any conversation to confirm what they were doing. This task led approach did not support the dignity of the person and was a missed opportunity for a positive interaction.

Supporting people to express their views and be involved in making decisions about their care

- People were not consistently supported to be involved with decisions or express their views.
- One person described how staff had previously moved a table into their bedroom and they had all their meals in there for some time. They explained that staff told them they were disturbing other people at meal times and must take all their meals in their bedroom. The person said this had not been their choice and they preferred to be in the dining room so this had been an upsetting experience for them. They described feeling much happier "once they were allowed" to join people in the dining room again. This showed that people's views were not always listened to or respected.

● During the inspection we arrived at 7.15am to find seven people were already dressed and asleep in their chairs. Staff on duty described how people had chosen to get up early or had needed support with personal care and had chosen to get dressed. They told us some people had been supported to get up at 6am and earlier. We were not able to verify this with all the people and there were no records to confirm why people were up and dressed early, whether they had received personal care and whether it was their choice to get up. Some people described having been woken up early by staff. One person told us their choice was to get up at about 9am and they did not realise how early it was and said they did not know why they were up and dressed so early. When we told them they had been dressed and asleep in the lounge at 7.15am they said, "That is early isn't it? I have no idea why I was up at that time." Another person told us they felt tired saying, "I don't know why they have to wake me up so early." A third person said, "I get up when they wake me, it helps them out and I don't mind." They did not realise the time and told us they thought it was about 8.30am. This did not demonstrate that people's views and choices were respected regarding their daily routine.
● We asked the provider why people were being supported to get up so early. They told us they thought this was a normal pattern for people. We looked at records for the previous days but could not identify what time people were preferring to get up . Only one person's care plan identified that they liked to get up early.

Respecting and promoting people's privacy, dignity and independence
● Staff were not consistently supporting people's independence and respecting their dignity.
● During the three days of inspection our observations were that people were receiving mixed standards of care. Some staff knew people well and understood their needs and preferences. Some agency staff did not know people well but were kind and caring in their approach and treated people with dignity and respect. One person told us the staff were kind, saying, "They have done very well when you think how much they have to do."
● Some staff were not aware of people's individual needs and did not always support their dignity in a respectful way. For example, we observed how a staff member wiped a person's face after eating. They did not ask the person or offer them the opportunity to wipe their own mouth but instead bent forward and wiped their face. The person was visibly startled by this and pulled away showing they did not enjoy the experience. A similar reaction was observed with a second person, but the staff member did not appear to notice people's discomfort.

The failure to provide care in a kind and compassionate way that supported people's dignity, was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection on 8 May 2018 this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

At the last inspection on 8 May 2018 we made a recommendation that the provider obtain information, sources training and implements policies and procedure in relation to compliance with the AIS. At this inspection there had been no steps taken to address the recommendation and it remained that the provider was not compliant with AIS.

- Some people had auditory and visual sensory loss. Staff had not assessed their communication needs or made any adjustments to ensure that their communication needs were identified, flagged and met. This was not in line with Accessible Information Standards

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

- Care plans were generalised and not well personalised. People's choices and preferences were not always included. For example, a care plan encouraged staff to engage with a person and talk to them about things that they were interested in but did not identify what their interests were. Another care plan identified that staff should be aware of the time the person liked to go to bed but the time had not been included. This meant that staff did not have all the information they needed to provide personalised care to people, particularly if staff were not familiar with people.
- Regular reviews of people's care and support had been recorded but were not always effective. We noted a monthly care plan review had been recorded once a month for twelve months, but the information in the review remained unchanged each time apart from the date. This indicated that there had been no changes for a person over a period of 12 months. When we spoke with the person they told us about a number of changes including their concerns about an increase in their weight. They described having a discussion with staff about discomfort in their legs, potentially having an effect on their mobility but that no action had been taken to address these concerns. This information had not been captured in the monthly care plan update and there had been no changes to their care plan to support these concerns. This did not support personalised, responsive care or involvement with the person in planning their care.
- Records identified that some people had unwitnessed falls. To reduce the risks of further falls their care plans identified that they should be encouraged to stay within communal areas, so staff were around to supervise them. Care plans did not show consideration of how to support people's choice to move around

their home independently. We observed how one person liked to walk around but was continual encouraged to stay within one area of the building where staff were present. There was no evidence that advice had been sought from a competent person in how to support people's mobility and balance the risks and benefits of enabling them to mobilise independently.

● Staff did not demonstrate an understanding of how to support people with specific needs and behaviour. For example, one person was independently mobile and wanted to move around frequently. Staff consistently used restraint, including with medicines, to prevent the person from moving around, rather than seeking personalised solutions to support them.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At the last inspection on 8 May 2021, we made a recommendation that the provider obtain information, in respect to developing the activities programme further to be more inclusive and person centred for people, from a reputable source, such as the Social Care Institute for Excellence (SCIE). At this inspection there had not been an improvement and people were still not receiving social stimulation and activities that were relevant for them.

● During the inspection an external entertainer was providing musical entertainment for people and a staff member was seen supporting some people to decorate Christmas cards. People were engaged and clearly enjoyed these activities. At other times there was little stimulation for people. Staff were busy and did not have time to sit and talk to people or support them with activities.

● Although some staff knew people well, there was currently a heavy reliance on agency staff who were not familiar with people, their needs, interests and preferences. A staff member told us that current staffing challenges meant that there was less opportunity for people to have social activities or to go out. Records of people's daily activities were sampled and did not identify that they had been involved with person centred activities or that they had been able to go out in the local community.

● One person told us they had enjoyed going for a walk on the seafront in the summer but they had not been able to go again since then. We asked another person what they liked to do to pass the time. They told us, "I sit and wait for my family."

● Relatives told us that they had been supported to visit their relations and a conservatory in the garden was used for these visits.

The continued failure to provide care that was personalised, responsive to people's needs and reflected their preferences was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Concerns and complaints were not always recorded and addressed.

● The provider had a system for recording complaints and concerns. People and their relatives told us they knew how to make complaints and most said they would talk to the registered manager if they had concerns. Some people said they had not always felt comfortable to report complaints or concerns. One person described feeling intimidated and targeted by a staff member. They had not felt able to tell the registered manager or the provider about their concerns because they did not feel they would be believed. They said, "The (registered) manager is very good friends with them so I couldn't tell her about it."

● A relative described having received a defensive response when they raised a complaint with a member of staff, they said they had not felt comfortable to pursue their concerns. The complaint had not been recorded and there was no information to show that any action had been taken to address the concerns raised. The lack of recording meant that the provider had not been aware of this complaint.

End of life care and support

- Some people had been supported to plan for end of life care.
- We noted that end of life wishes were recorded for some people.
- We were not able to view a care plan for end of life care because this had been archived and could not be found. Medicine records showed that anticipatory medicines had been prescribed for people at end of life.
- We viewed a number of compliments received from relatives about the care provided to their relation at end of life.

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 focussed inspection on 27 July 2021 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 the last inspection on 27 July 2021 there was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because managers and staff were not always clear about their roles and understanding of regulatory requirements. This had placed people at risk of potential harm. The provider sent us an action plan detailing the improvements they would make. At this inspection improvements had not been made, and we found continued and new breaches of the regulations.

- At the last inspection shortfalls in systems for the oversight and governance of the service were identified. At this inspection systems had not improved, and further widespread concerns a and significant shortfalls were identified.
- The registered manager had been registered with CQC since 1 September 2021. They were not present during this inspection. The provider had arranged for a person to be in charge of the day to day running of the service in the absence of the manager. The person in charge told us they were familiar with the service but was unable to have a handover and therefore did not know where documents were kept or how some systems worked.
- Systems to support the oversight and governance of the service were not effective. This meant that potentially abusive practice had not been identified and reported.
- There was a lack of oversight of incidents and accidents. This meant that signs, patterns and trends that might indicate abuse had not been identified. Appropriate actions to report potential abuse had not been taken in line with local safeguarding procedures. This meant that the provider had not assured themselves that people were protected from abuse.
- Audits of care plans had not identified shortfalls in guidance . The quality of care plans and risk assessments had not been monitored to ensure that staff had the information they needed to care for people safely. For example, there was conflicting information about choking risks and staff, who needed to know, did not have all the information they needed. Some people had health conditions including diabetes and epilepsy but risk assessments and care plans were not in place to support them. A person had a head injury following a recent fall. Although checks had been put in place following this head injury, records indicated that staff had not completed these checks consistently. This meant the provider could not be assured that people were being supported safely and that risks were effectively identified and managed.
- Systems for monitoring the safe management of medicines were not effective. This was identified at the previous inspection and there continued to be unsafe systems for managing medicines. This meant that

medicines were not always accounted for and the provider could not be assured that people were always receiving their medicines safely.

● Systems to ensure that there were enough suitable staff were not effective. The provider had continued to not always follow their own policies in respect of recruitment. This shortfall was identified at the last inspection and there continued to be a risk of employing unsuitable staff. The staff rota was being arranged on an ad hoc basis. The person in charge and the provider told us they were not able to confirm staff arrangements for the coming week as they had not been confirmed by agencies they had approached. This meant that the provider could not be assured that there were enough suitable staff to care for people including over the forthcoming Christmas holiday period. Records of rota's to show how staff had been deployed in previous weeks and months could not be found. The provider could not assure themselves that there was always enough staff on duty to care for people safely.

● There was no system in place to ensure that temporary or agency staff, who were unfamiliar with people's needs, were able to support people effectively. An agency staff member told us this was only their second shift at the home and they did not know people, they confirmed that they had not received an induction or handover about the people they were supporting and relied on the other staff member to guide them.

● There was no inventory system to safeguard people's personal possessions including jewellery and items of value to people. The person in charge told us that items of value that were kept in a safe, belonged to people who had died. There was no system to identify who the items belonged to, what had been returned to people's family members and when. There was no system to confirm who had access to the safe or guidance for staff about how this should be managed to ensure that people's possession safeguarded. This meant the provider had no way of knowing if all items were accounted for.

●The person in charge told us they visited the service regularly to support the provider's oversight of the service. The were no records of these visits and no audits had been undertaken by the provider or the person in charge to assure themselves of the quality of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 leadership of the service did not promote a positive, person centred approach.

● The person in charge provided a list of staff who were currently employed at the service. This included staff who were related to the registered manager. The provider did not have a policy in place to manage possible conflicts of interest or to support an open and fair culture within the staff team.

● The culture of the service was not open and transparent. People and their relatives did not always feel able to raise concerns because they feared recriminations. Examples are given in the responsive domain of this report.

●Staff did not always display a positive attitude to people, and this was evident in the language used in records and from our observations of some staff during the inspection. These incidents are described further in the caring domain of this report.

● People were not supported achieve good outcomes. Records showed that four people had unplanned weight loss but the lack of accurate records relating to food and fluids meant that the provider could not be assured that people's nutrition and hydration needs were being met.

● During the inspection we noted that fluid charts had not been completed since the previous day at 1pm. Later that morning, we saw a staff member completing the fluid charts retrospectively. They had also completed the food charts for breakfast that morning. We asked the staff member how they knew what food and fluids people had, as they had not seen this themselves. They explained that the person in charge had instructed them to complete the records retrospectively and told them what to write. We noted four incorrect entries for people who we had observed at breakfast time. This meant that the integrity of the records was not assured and could not be relied upon as an accurate account of what people had to eat and

drink, including for people who had needs associated with choking or malnutrition and hydration.
● Staff had not maintained accurate, up to date and complete records relating to people's care and treatment. Records had not been archived and stored securely. We found piles of records in unused rooms and stored in the attic of the service. This meant that the provider was not able to account for the care provided to people and records were not always accessible and safely stored. For example, we asked to see the records for a person who had recently passed away but these could not be found.
● The provider told us they visited the service, with the person in charge, on a regular basis but were not aware of the many shortfalls that we found regarding the management of the service. The lack of systems for checking the quality and safety of the service meant that the duty of candour had not been met by the provider.

Continuous learning and improving care
● At the last inspection we identified three breaches of regulation 12, 17 and 19. The provider sent us an action plan following the last inspection on 27 July 2021 identifying the improvements they would make by October 2021. They had not followed their plan and the standard of care and safety at the service had deteriorated further. Previous breaches of regulation had not been met, recommendations for AIS had not been followed and we also identified new breaches of regulation.
● Poor quality assurance arrangements and lack of oversight meant that there was little evidence to support continuous learning or improvements. Audits that were in place were not accurate and robust. For example, the registered manager had completed an audit of medicine administration dated 30 August 2021, this did not identify any issues or actions needed but we found numerous medicines left in old medicine cabinets that were not all accounted for.
● Monitoring incidents and accidents was not effective in identifying patterns or trends. The provider did not have a system to assure themselves that thorough investigations were undertaken in line with their own policy, and that appropriate actions had been taken to prevent further incidents.
● The provider and the person in charge told us they did not undertake their own audits to check the standards of care provided but relied on their observations and talking to people and staff when they visited. Failings in the management of the service had not been identified and opportunities for making improvements had been missed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The culture of the service was not open and transparent and did not support constructive engagement with people, their relatives or staff members.
●There was little engagement with people and staff did not always understand how to provide a good quality service, considering people's diverse needs and views. Concerns including safeguarding concerns, had not been identified and dealt with in an open and objective way. Complaints had not always been recorded and addressed. The provider told us they were unaware of poor practice issues ● Some staff and people had witnessed unsafe and unkind practice but there was a reluctance to raise concerns. Most people and their relatives spoke highly of staff and described them as being friendly and kind. A relative told us about their concerns but had felt intimidated when they spoke to a staff member. Some people who had dementia expressed anxiety. For example, one person told us, "I must behave myself."
● The lack of openness and transparency meant that staff had not been engaging effectively with other agencies. Although there was regular contact with the GP, staff were not working collaboratively with other health and care professionals. For example, there was no evidence to show that staff had sought advice from health care professionals about support for people including with risks of choking, risks of falls, diabetes and supporting mental health issues. The provider had failed to recognise the closed culture that had developed at the service and had not taken action to ensure openness and transparency when risks had

been identified.

The failure to have effective systems in place to monitor the quality and safety of the service and to ensure that accurate, complete and contemporaneous records were kept was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.