Tamhealth Limited

Highfield Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Highfield Care Home is a care home set across two floors and is registered to provide accommodation and personal care for up 54 older people some of whom are living with dementia. At the time of our inspection 36 people were living at Highfield Care Home.

People's experience of using this service and what we found
People were not always protected from the risk of harm. When people sustained unexplained bruises or skin tears these were not investigated or reported to external safeguarding authorities.

Lessons following incidents, accidents or complaints were not learnt. Information was not shared with staff, so the service had not improved the care that staff provided to people.

There were not always enough staff effectively deployed to meet people's needs in a timely way. Staff had not received training to understand the needs of the people they supported, and their competency and skills were not assessed.

Staff did not always follow guidance from health and social care professionals when supporting people at risk of choking or at risk of developing pressure ulcers. People's dignity was not always promoted.

People who developed pressure ulcers or who's health needs changed were not always referred to health care professionals in a timely way. Staff were not always responsive to people's changing needs to ensure that the care and support they provided to people was personalised.

The registered manager had not investigated or responded to complaints raised. The governance systems in place were not used effectively to identify and improve the service.

The provider failed to ensure that people received a good quality service in a personalised and safe way. People were not always 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.

People's medicines were managed safely. People had been provided with activities and opportunities to pursue their hobbies and interests.

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 23 November 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found

that the provider was still in breach of regulations. This service has been rated requires improvement for the last four consecutive inspections.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, complaints, dignity and governance systems at this inspection.

For requirement actions of enforcement which we are able to publish at the time of the report being published:

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always 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.

Highfield 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 Care Act 2014.

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

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

The service had a manager registered with the Care Quality Commission. 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.

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 12 people who used the service and eight relatives about their experience of the care

provided and a visiting health professional. We spoke with seven members of staff. In addition, we spoke with the Chef, the maintenance operative, the registered manager and the regional support manager. 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 six people's care records and multiple medication records. We looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with the regional manager and the provider's director of care.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess and mitigate risks to people's health and welfare to keep them safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were at risk of harm in case of a fire. This was because the provider failed to upgrade the environment following a fire risk assessment completed in June 2019. The fire risk assessment highlighted four actions to be completed within a maximum of three months. These were to extend the automatic smoke detection in areas where this was not in place and repair the laundry door to provide 30 minutes fire resistance. The provider had not put in place temporary measures to manage the risk like temporary smoke detectors. Further maintenance issues were also found in relation to some of the electrical installation in the home. All these actions were outstanding when we inspected.
- The failure to act on the above action points placed people at significant risk. In the event of a fire, systems would not have been in place to provide at the earliest opportunity warning of any smoke in the building.
- Staff had not always followed guidance from health professionals and this put people at risk. For example, a health professional advised staff to sit up and observe a person for signs of aspiration and staff had not done this. Another person had been prescribed level five consistency food by the Speech and Language Therapist (SALT), however staff asked the kitchen staff to give level four consistency food. This meant that there was an increased risk of this person aspirating food. A third person had not been referred to SALT for a specialist assessment, although the choking risk assessment tool indicated that they needed to be assessed.

- In the previous two inspections we reported that people sat for long periods of time in wheelchairs. In this inspection we observed this was still the case. We observed three people who sat in their wheelchair for a period of six hours, without staff offering to support them to move to a more comfortable chair or offering people assistance with their personal care and continence needs.
- We found two people who had developed pressure ulcers whilst being in the home. Both these people required staff to help them change their position. The repositioning charts showed that they sat in their chairs often from 9am to 6pm without being re-positioned.

The provider failed to ensure people were protected from the risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The provider responded immediately after the inspection. They confirmed they had commenced work to ensure actions from the fire risk assessment were completed and people were protected from the risk of harm

Staffing and recruitment

At our last inspection the provider had failed to ensure that there were enough staff employed to meet people's needs safely at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

● People and relatives raised concerns with respect to weekend staffing numbers. One person said, "They could do with more staff. When I ring the bell I sometimes have to wait." A relative said, "The staff are generally good and caring and know what they're doing, but there's next to no one available on weekends." Another relative said, "The staff are incredibly hard working and very caring, but there's not enough of them; they're very light on weekends."

● The call bell log showed that people at times waited up to 40 minutes for their call bells to be answered.

● The registered manager told us they based staffing on the needs of the people living in the home. However dependency assessments had not been carried out since August 2019 to ensure adequate staff numbers were deployed.

● We saw that staff were not present in communal areas at all times to offer people assistance when they needed.

The provider failed to ensure there was enough effectively deployed staff to meet people's needs in a timely way. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse Learning lessons when things go wrong

● People told us they felt safe in the home. However, relatives told us they had concerns about the safety of the premises as members of the public could access the home without staff knowing who was in the building.

● People sustained bruising and injuries, often these were unexplained. For example, a person who needed staff support with mobility had sustained bruising and two skin tears on three different occasions. Unexplained injuries were not investigated or reported to safeguarding authorities. This meant that no measures were taken to protect people from the risk of harm.

● The registered manager reported monthly the number of wounds people sustained to the provider's head office. They reported 80 wounds in the last six months. However, we found injuries recorded in people's care records which had not been reported to the provider.

● Not every staff member knew what their responsibility was under the safeguarding procedure. Some of the nursing staff said that reporting unexplained injuries to external safeguarding authorities was not their responsibility.

● There were no lessons learnt process used by the registered manager to improve care practices. Accidents and incidents were not analysed for trends and patterns, staff's competencies for manual handling practices were not monitored in response to the high number of unexplained injuries people sustained.

● In October 2019 17 people out of 36 were diagnosed with urinary tract infections, chest or wound

infections. There was no action taken by the registered manager to observe care practices, investigate or report this to external health agencies.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People's medicines were managed safely. Medicine administration was completed in accordance with good practice. Medicines records were completed accurately and the sample of medicines we counted tallied with the amount recorded. Staff had received training and there were protocols in place for medicines prescribed on an 'as needed' basis. This helped to ensure that people received their medicines in accordance with the prescriber's instructions.

Preventing and controlling infection

● There were infection control procedures in place and regular cleaning in the home. Generally, the home was clean, however there were unpleasant odours all morning in the conservatory on the first day of the inspection and on the first floor on the second day.

● Staff were seen washing their hands and using personal protective equipment when needed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- At the last inspection we found that staff's training in subjects considered mandatory by the provider had lapsed and staff were not provided with training to understand the needs of the people they supported. At this inspection training was still not provided effectively and staff's competency to carry out their roles effectively were not tested. The evidence found in this inspection demonstrated that staff lacked essential skills and abilities to provide effective care to people.
- Some people developed pressure ulcers and on occasion staff failed to request specialist support in a timely way. For example, a person developed a pressure ulcer. Following a review of their care needs a social care professional established that there was a delay in seeking health professional input and recommended further training for staff. The registered manager told us they hoped the person's wound would improve and they only referred the person to a health professional when the wound got worse.
- Staff were not provided with the training as recommended by the social care professional. The registered manager told us they put forward some nursing staff to have the training, however they did not plan to provide care staff with training to enable them to meet people's skin integrity needs more effectively.
- The registered manager failed to ensure that the nursing staff working in the home were up to date with their training and developed their skills further. For example, only one nurse had completed catheter training in 2016. People's care records evidenced that some people had frequent urinary tract infections or presented signs and at times there was a delay in seeking medical advice.

The provider failed to ensure staff were suitably qualified, skilled and competent to meet people's needs effectively. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they had regular supervision with their line manager and they felt supported. One staff member said, "I had two or three supervisions in the last nine months. I feel supported."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- People's needs were assessed prior to moving into the home. Care plans were developed to give staff guidance in how to meet people's needs effectively. However, care plans were not always developed for every identified need people had. For example, a person had a learning disability. There was no care plan developed to give staff an understanding how this need impacted on the person's life. The registered manager told us they considered the learning disability this person had a secondary need to their nursing

needs. This was not in line with current best practice for meeting people's needs holistically.
● Care records showed that external health professionals visited people when staff requested their visits. There were regular visits from the GP, speech and language therapists and other health care professionals.
● At times there was a delay in staff reporting and asking specialist health care professionals advice when people's needs changed. For example, when people lost significant amount of weight or presented signs and symptoms of a urinary tract infection.

Adapting service, design, decoration to meet people's needs
● At the last inspection we found that there was a rolling redecoration plan in place to ensure that some areas of the home were improved.
● The environment had been improved in places. Several bedrooms were re-decorated, and the dining room had been refurbished. However, there were still areas in the home which looked tired and dated. Further improvements were needed to ensure people lived in a nice, comfortable and clean environment suitable for their needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us the food was tasty and choices were offered. One person said, "The food is very good on the whole and we have a choice." Another person said, "We do get nice food."
● Staff were attentive to people. Where needed staff offered to support people with their meal and prompted people to ensure a good food and drink intake.
● The chef was passionate about meeting people's nutritional needs. They were taking part in residents' meetings and sought people's feedback about the quality of the meals to ensure they adapted the menus to people's likes.
● People's dietary needs were well known to the chef. However, we found one example where staff did not give the correct information to the chef and one person was getting level four consistency diet instead of level five. This meant that there was a potential risk of chocking for this person.
● The chef told us they prepared fortified diets for the people who staff told them needed this. However, staff failed to identify that some people were losing a significant amount of weight and this could have had a negative impact on their health.

Supporting people to live healthier lives, access healthcare services and support
● Staff worked in partnership with health care organisations appropriately sharing information about people to ensure that the care and support provided was effective and in people`s best interest.

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.

● People were asked to consent to their care and support by staff throughout the day. Where people could

they signed consent forms in their care plans so that their personal information could be shared with professionals if needed.

● If needed staff carried out mental capacity assessments to establish if people could take specific decisions. However, these assessments were not carried out in line with the MCA principles. They were not decision specific and best interest decisions were not taken following a best interest process.

● DoLS applications were submitted to local authority by the registered manager to ensure that any restrictions applied to people`s freedom to keep them safe was done lawfully. We found that one authorised DoLS had conditions attached to this. These conditions were not met by staff. For example, one of the conditions asked staff to accurately record the use of 'as and when' medicine given to a person, to record their behaviour and regularly review the use of it. This had not been done.

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People said that staff were caring, friendly and respectful towards them. They said there was a friendly atmosphere in the home and throughout the visit friendly interactions were observed between staff and residents. One person said, "They're good people. They're so caring and go out of their way to help you."
- Some staff members were kind and caring towards people, promoting their dignity. However other staff members embarrassed people in front of others and people's dignity and privacy was not upheld. For example, there was a malodour for up to an hour in the conservatory suggesting that a person may have needed help with their continence. A staff member asked loudly, in front of eight people and two inspectors, who was responsible for the odour. When the staff member had no answer, they got close to each person until they identified who the person was. They communicated this on a raised voice to everyone and loudly encouraged the person to go with them to the toilet because they needed assistance with personal care.
- Another staff member loudly asked a person to go with them so that they could shave their beard. This person was a female resident and the staff member drew everyone's attention to this person.

This behaviour did not protect people's rights and dignity. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's care plans contained evidence to show they were involved in reviews of their care and where appropriate their family members.
- People and relatives told us that people's choices were respected by staff. One person said, "I've always been looked after well here, and I have peace of mind which is what I want." A relative told us, "We come in every day and know that they turn [person] every two hours. They really take good care of them. The staff are kind and [person] likes the staff."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

● People and relatives told us they knew how to raise any concerns and t the management team listened to their grumbles. One relative said, "I would talk to [registered manager] if there's a problem. I did when clothes had gone missing and the issue was promptly dealt with."

● However, when more serious complaints were made in writing these were not investigated or responded to. Three complaints were held on file since the previous inspection. The registered manager had spoken to those people who had raised the concerns but had not concluded their investigation or informed them of the outcome.

● One complaint raised in July 2019 related to the lack of repositioning a person had and we found this issue continued at this inspection. The registered manager told us they had not responded to the complaints in front of the provider's area support manager. When the area support manager heard of the five months delay in responding to this complaint they said to the registered manager, "Just give it over to admin and get them to write a letter." This did not demonstrate an approach from the management team to confirm that people's concerns and complaints were listened to and responded to and used to improve the quality of care.

● A complaints policy was in place and people were provided with a copy of the procedure. However, the procedure had not been followed by the registered manager.

This was a breach of regulation 16 of the Health and Social Care Act 2008 [Regulated activities] Regulations 2014.

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

● People's care plans were developed and, in most cases, detailed their likes, dislikes and preferences. However, staff did not always deliver care and support as detailed in the care plans. For example, some people's care plan detailed how important was for them to change position regularly. Staff recorded on repositioning charts the position people were in, such as sitting in their chair, but did not attempt to re-position people to help promote their skin integrity?

● People's needs were not always responded to with prompt actions. One person said to staff in their review meeting that they felt depressed and had lost their appetite. There was no action from staff to refer the person for specialist support to help them with their mood.

● When people's needs changed staff did not look to establish how the changes affected people holistically. For example, one person had a long-standing wound which got worse and infected in October 2019. This person had lost a significant amount of weight in the previous month. However, staff did not consider that their wound could deteriorate due to poor nutritional intake and they had not responded to this need. The

person had to be admitted to hospital with their infected wound which deteriorated further.

This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
● People`s care plans detailed what communication needs they had. Some people's care plans detailed that they reverted back to speak their native language. We observed a person being supported by a staff member who spoke with them in their own language and the person was communicative, smiling and clearly enjoyed themselves. However, this person's care plan detailed that staff should remind them to speak English. There was no consideration to help the person to be involved more in their care by giving them the information in a way they could understand better.
● One relative told us, "It seems a bit old fashioned; there's no use of computers to help communication and they could make better use of their facilities."

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
● People were happy with the activities provided. One person told us, "The activities are very good. We have weekly exercises and people come in to do arts. We have scrabble which I love. We have a lovely garden, but there's no gardener here. That's something that I think needs doing."
● The activity coordinator was passionate about their role. They spoke to us with care and passion about supporting people. They said, "We are very much led by them [people]; we do what they want to do."
● There was a Wishing Well programme where people expressed a wish they had, and the activity coordinator organised for this to be accomplished. For example, a person wanted something from a different culture. The activity organiser arranged for items from this culture to be purchased for the person.
● In monthly meetings people were asked about what activities they liked doing and as much as possible this was arranged. For example, people went out to watch the fireworks, trips were organised, and in-house entertainment and activities were also provided.

End of life care and support
● The service provided end of life care for a high number of people. Care plans detailed whether people wanted to remain in the home or not when they neared the end of their life. People were happy with the support they had. One person said, "I couldn't ask for a better place to see out my time."
● A palliative care team from a local hospice helped the service ensure that people could die in the home and were not sent to hospital if this was what they wished for. However, the registered manager had not considered the impact of having a high number of people dying in the home had on staff. One staff member said, "It's very hard and distressing. We had occasions when four people died in one week."
● Staff involved the GP in people's care to ensure they could be kept comfortable and pain free.
● People's care plans needed developing further to ensure if people had any specific wishes for their final days or hours, so these could be known to staff.

Inadequate

Is the service well-led?

Our findings

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

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

In two previous inspections we found the provider in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of contemporaneous records and lack of effective audits to identify and improve the quality of the care people received. At this inspection we found that the provider had not made the improvements needed and were still in breach of this regulation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service has not met all the fundamental standards since September 2013. Since that time there had been four further inspections where CQC identified improvements were required. The management team had failed to improve the service. At our last inspection we found three breaches of regulations. At this inspection we found continuous and further breaches of regulation that placed people at risk of harm.
- Governance and quality assurance systems did not effectively identify and address concerns. For example, critical priority works for fire safety had not been acted upon and at the time of inspection left people at risk of harm due lack of fire detection in place. This was only addressed when we asked the provider to do so. The fire quality assurance had been signed off by the regional support manager as completed in advance, meaning that no effective checks were in place.
- Staff reported to the management team any incidents that placed people at risk of harm. The registered manager did not always review and investigate these. If a skin tear, bruise or pressure wound required reporting, they had not always reported to the local authority safeguarding team or internally to the provider. For example, a person had an unexplained bruise on their thigh in March 2019. This had not been reported to the provider or external safeguarding authorities for further investigation.
- Information and data collected by the registered manager was not analysed for any trends and patterns so that actions could be taken to improve the service. For example, monthly wound and infection monitoring had been completed for October 2019. This showed 18 people had a new infection, however no analysis had been carried out to identify themes, trends or to identify if others may be at risk. We found the same lack of attention with other areas such as weight, pressure care, insufficient detail in care records and staff deployment.
- The registered manager told us they regularly reviewed the time it took staff to respond to call bells. We were provided with the call logs for October 2019. This showed significant delays. The registered manager or senior managers had not identified this as an issue. When we requested call bell logs for November we were provided with inaccurate records. It showed numerous calls answered across the home at exactly the same time. When we asked the regional support manager to review this, they told us, "The only logical reason I

can deduce for same minute activation and deactivation of call bells is an instant response by staff to the resident's room." This was inaccurate and further demonstrated that robust checks were not made of the quality assurance data.

● The provider had a lack of oversight of how the service was being run. Monthly monitoring had not been carried out. The last provider audit was carried out in July 2019. The registered manager had not completed their monthly reporting to the provider around key areas, such as injuries, wounds and infections. This had not been identified by the provider. This meant that systems used to monitor the performance of the home and registered manager were not effective.

● Team meetings had not been regularly held. The last minutes we were shown were from a meeting in March 2019. Although staff were able to raise their views or opinions, the registered manager did not consider staff opinion. We saw staff raised their concerns around staffing levels and deploying care staff to work in the kitchen since January 2019. This was still an ongoing issue at the time of our inspection, the registered manager had not addressed the issue.

● The service was providing care without the appropriate service user band being added to their registration. A person with a learning disability was being supported at the home. Staff had not received specific training to meet this person's individual health and welfare needs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Inadequate leadership and management identified at this inspection and previous inspections did not promote a positive and person-centred culture in the home.

● The registered manager had not informed or shared with staff the nature of the complaints raised, safeguarding outcomes or incidents to discuss.

● People's views about the quality of care were sought through regular meetings with the activity staff. A new survey was being developed so the views of people and relatives could be gathered and used to improve the service. There was no current strategy in place to share learning and strive to improve the service to provide personalised care and support for people.

● People's care records did not inform staff how to effectively and meaningfully engage with people or support their equality characteristics. For example, people living with dementia or a learning disability.

● We reported in the last inspection that people's care records were hardly legible, and we could not read the information about their support needs. At this inspection a health professional reviewing a person`s care needs told us, "Records are not legible so it`s hard to read. I try but I will need a staff member to support me to get the information I need."

● Staff told us they felt listened to and respected by the registered manager. Staff told us improvements had been made since the last inspection, however when we asked what these improvements were, staff referred to the environment.

Inadequate systems and processes to assess, monitor and improve the service meant that lessons failed to be learnt. The provider had failed to reduce or remove risks where possible which had a negative impact on people using the service. Since 2013 people had continually been provided with a poor service. This was a continuous breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.

● Duty of candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. There was no evidence in people's care records, discussions with staff or management to demonstrate where this had occurred.

This was a breach of regulation 20 of the Health and Social Care Act 2008 [Regulated activities] Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Staff were not responsive to people's changing needs and the care and support people received was not always personalised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not always promoted by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were protected from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment When people sustained unexplained bruises or skin tears these were not investigated or reported to safeguarding authorities. There were no lessons learn to ensure plans could be developed to keep people safe from harm.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints When complaints were received by the registered manager in writing these were not investigated or responded to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered manager had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there was enough effectively deployed suitably qualified, skilled and competent staff to meet people's needs in a timely way.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Inadequate systems and processes were used to assess, monitor and improve the service. This meant that lessons failed to be learnt. The provider had failed to reduce or remove risks where possible which had a negative impact on people using the service. Since 2013 people were continually been provided with a poor service.

The enforcement action we took:

vary conditions