Four Seasons Homes No.4 Limited

Marquis Court (Tudor House) Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Marquis Court (Tudor House) Care Home is a nursing home providing accommodation and nursing and personal care to a maximum of 52 older adults. People are supported over 2 floors at the home. At the time of our inspection 26 people lived at the home some of whom were living with dementia.

People's experience of using this service and what we found
For more details, please see the full report which is on the CQC website at www.cqc.org.uk
People had to wait for their care, as there were not enough staff to support them in a timely way. People did not receive the support they required around mealtimes, pressure care and wound care. This had resulted in people losing weight and the condition of their skin deteriorating. People experiencing periods of anxiety and distress did not have care plans to enable staff to meet these needs in a consistently safe and effective way.

People's dignity was not promoted. Staff used disrespectful language to describe people's needs. People had limited access to activities and personalised care in line with their needs and preferences. People and relatives were not happy with social activities available to occupy their time. People were not safeguarded from potential harm as they were not receiving the care and support they required.

People were not supported in a safe environment as doors were left open to rooms containing harmful substances. People did not have end of life care plans in place which comprehensively explored their needs and wishes at the end of their lives. We have made a recommendation about supporting people in line with their preferences at the end of their lives.

Although people and their relatives knew how to complain, complaints were not always acted upon. Governance systems were ineffective as they had not identified the concerns found at this inspection. Leadership at the home was inadequate and improvements had not been identified or embedded to ensure people experienced good quality care and support. The home had not received a rating of good overall since they registered with us in 2014.

Rating at last inspection and update
The last rating for this service was requires improvement (published 03 September 2019) and there was a breach of regulations. 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 the provider remained in breach of regulation and further breaches had been identified. This service has been rated requires improvement for the last 9 consecutive inspections.

Why we inspected

This inspection was prompted by information being shared from external partners that the home had improved since our last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed to inadequate based on the findings of this inspection.

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

We have found a repeated breach in relation to the governance and oversight at this inspection. We have also found further breaches in people's safe care and treatment, person centred care, nutrition and hydration care and staffing. Please see the Safe, Effective, Responsive and Well-led sections of this full report. 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marquis Court (Tudor House) Care Home on our website at www.cqc.org.uk.

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 continue to monitor information we receive about the service, which will help inform when we next inspect. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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.

Marquis Court (Tudor House) 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.

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

Inspection team
The inspection was undertaken by four inspectors over two days.

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

Registered manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

The registered manager was not available during our inspection. A regional support manager and a regional manager however, were available to respond to questions we asked and to provide us with information that we requested.

Notice of inspection
The first day of this inspection was unannounced. On the second day we announced we would be visiting.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. 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 contacted the local authority for feedback on the home. We used all this information to plan our inspection.

During the inspection
We looked at the premises including communal areas, lounges, dining areas, bathrooms, the laundry, and the medicine/treatment room.

We spoke with 6 people who used the service, 7 relatives and 11 members of staff including care staff, senior carers, nurses, the regional support manager and a regional manager (senior managers). We did this to gain people's views about the care and to check that standards of care were being met.

We reviewed a range of records, including 12 people's care records, to see how their care and support was planned and delivered. We looked at medicine systems and a selection of medicine records. We also looked at records related to how the service operated and was managed and reviewed two staff files to check if staff had been recruited safely.

We made observations during the day and 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.

After the inspection
We held a video call with the regional managers and a managing director and gave the provider the opportunity to send us any audits that related to the service. The provider sent us some information that we considered as part of our inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At our last inspection we rated this key question as good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● People did not receive the care they required in relation to pressure relief as there were not enough staff to complete this. For example, one person who required 2 hourly pressure relief did not receive pressure relief for over 12 hours. This had resulted in a deterioration to their skin condition.

● Multiple other people requiring regular support with their pressure relief did not receive this and we saw a further 2 people had experienced a deterioration in their skin condition as a result of this.

● There were not enough staff to ensure people's basic care needs were met in a timely way. For example, people, relatives, and staff told us of occurrences where people at times did not have support with personal care until midday or later. One staff member told us, "Everyday this is happening. At 4 pm I still have residents that have not been bed bathed."

● People did not receive the support they required to eat and drink as there were not enough staff. During our inspection we observed 7 service users on the first floor with their lunch in front of them which had gone cold at 3pm. People's lunch had been served to them at 12.30. 3 people on the ground floor required prompting, encouragement or supervision at mealtimes. We observed they did not receive this. This placed them at risk of choking, dehydration and malnutrition.

● Relatives felt the home needed more staff. One relative told us, "They are short staffed. It takes 30 minutes to get a drink."

● As there were not sufficient regular staff to meet people's needs, the provider used agency staff. Staff and relatives we spoke with, told us agency staff did not always have the skills and experience to meet people's needs effectively. One relative told us, "Regular staff know [my relative]. They are supposed to have a cup with two handles as they shake when they have hot drinks but agency staff don't know this." One staff member told us, "We get so many agency staff. You get used to them then they swap and you have to start all over again."

There were not enough experienced staff to meet people's needs and to keep them safe. This had resulted in people coming to harm and placed others at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment processes were safe as checks to ensure staff were fit to carry out their role had been completed.

Using medicines safely

● Medicines were not administered safely. For example, where people were prescribed medicines on an 'as required' basis, instructions for staff to inform them of when the medicine should be given were not always available. This placed people at risk of not receiving their medicines as prescribed.

● Medicines were not stored in a safe way. For example, the medicine room on the first floor was

disorganised and cluttered. There was a stack of medicines, on the floor up to work top level, that were no longer required awaiting return or destruction. There were also numerous supplies of supplements in storage boxes on the floor in addition to amounts already stored on shelves. This made the medicines room difficult to walk around in.

● Where people were prescribed topical medicines, they did not receive these as prescribed. For example, a person was prescribed medicine to support with their skin condition, however, from November to December they did not receive this cream on 23 days. This person had multiple pressure areas which were deteriorating. Not receiving their topical medicine to support with their skin condition placed them at significant risk of harm.

● People prescribed medicines in the form of a transdermal patch did not receive these safely as staff had applied people's patches to the same area of skin. This placed people at increased risk of skin irritation.

Assessing risk, safety monitoring and management

● People did not have care plans in place where they experienced periods of anxiety and distress. This meant staff had no clear guidance to enable them to support people in a consistently safe and effective way. This placed people and staff at risk of harm.

● Where people had care plans or risk assessments identifying they were at risk of dehydration and malnutrition; staff did not follow these to ensure people received the support they required. For example, a person who required prompting and encouragement with their food and drinks did not receive this. This person was losing weight. Failing to support them in line with their care plan placed them at continued risk.

● People requiring regular wound care did not receive this as prescribed. For example, a person's care plan stated they required staff to change their dressings every 3 days. However, on 9 occasions staff did not redress their wounds for 6 days. This person's wound had deteriorated.

● Harmful substances were not stored safely. For example, on the first floor there were multiple rooms left unlocked with the doors open where harmful substances were stored and people could access these.

● There was not enough mobility equipment to support people in a timely way. For example, there were 13 people on the first floor who required a hoist to support them to move around or transfer. However, there was only 1 hoist available on the first floor. This meant people had to wait for their care and support should another person be using the hoist.

● Where people had experienced weight loss staff had referred them to external agencies for review and further support. However, staff were not consistently providing people with the support external agencies recommended. For example, one person had a pureed diet due to risk of choking and required staff to observe them at mealtimes however did not receive this. This placed them at increased risk of choking.

Learning lessons when things go wrong

● Lessons were not consistently learnt in the service when things went wrong. For example, following a fall, it was identified a person may be safer if a sensor mat was used. Records highlighted there were problems with the installation of this equipment and maintenance were to chase this up. In the interim, no risk assessment or short-term care plan was put in place and the person had a second fall 4 days later and sustained bruising.

People did not receive consistently safe care in line with their needs and risks. This was a breach of Regulation 12 (1) (2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Infection Prevention and Control (IPC) processes were not always complied with. For example, we observed a staff member working in an area that was required to be kept clean and hygienic without a mask

or apron.
●There was a lack of disposable bags inside waste bins in toilets and bathrooms to ensure people and staff could dispose of waste effectively.
● We saw that some fresh food products were directly on the floor in a food storage area.
● The home was clean and there were plans in place to improve the décor of the building.

Visiting in care homes
● Relatives confirmed they could visit the home when they wanted to and people we spoke with were happy that they could receive their visitors.

Systems and processes to safeguard people from the risk of abuse.
● Staff knew how to report any safeguarding concerns, both within the service and externally. A staff member told us, "I have had safeguarding training. I would report, for example, financial and physical abuse, anything."
● Relatives felt people were safe from abuse. One said, "There have not been any concerns about bad treatment." Another relative highlighted, "No abuse incidents."
● Where safeguarding concerns had been shared with the management team, these had been raised to the Local Authority safeguarding team for further review.

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

- People's care plans contained details of their need and choices other than where they experienced periods of distress. However, people were not receiving their care in line with these. One relative told us that they had raised with staff that their family member only wants female staff to provide personal care. They told us the family member had been distressed when a male staff member was allocated the personal care task, and this was only prevented when the family member raised the concern.
- People did not receive care in line with their continence needs to promote their dignity. For example, a person was shouting for staff to help her as she needed the toilet. They did not receive this support until 12 minutes later, by which time it was too late. The person was visibly and audibly distressed by this.
- Information about people's care needs, likes, dislikes and personal histories was limited to their food and drink preferences in most people's care files.
- There was a lack of information available for staff about people's individual needs in relation to race, religion or sexual orientation.

Failing to ensure people had access to personalised care and support in line with their needs and preferences placed people at risk of harm. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

- Agency staff were not always given an induction to the home and enough information about the people they would be supporting. This meant people did not always receive effective care from agency staff as they did not have enough information about their needs and preferences.
- Staff received induction and training into their role. Staff told us the training was 'useful'. However, concerns we identified around medicines administration and basic care needs not being met indicated this training may not always have been effective.
- Some staff training was not up to date. The provider had an action plan in place to address this and make improvements to ensure staff competencies were up to date. We will check this at our next inspection.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- People were not supported to eat and drink safely in line with their needs. For example, multiple people who required prompting, encouragement and supervision with mealtimes did not receive this. 1 person who required this support and we observed did not receive it had lost 3.9kg in a week.

● Where people were at risk of malnutrition and weight loss and had food and fluid charts in place, staff had not recorded supporting people with food and drinks outside of their mealtimes. This placed people at further risk. One person had lost over 10 kg in 4 months.
● People did not receive adequate support with their fluid intake. Where people did not meet their set fluid target for the day, no further action was taken to ensure they received additional support with this need. This placed people at continued and increased risk of dehydration. On the 3 days prior to our inspection, of the 17 people on the first floor who required support with their fluids 15, 14 and 11 people did not meet their fluid target.
● Staff recorded in people's food charts people were 'offered but refused' food at mealtimes. However, one staff member told us, "We have people still waiting to be assisted at 4pm as you can't force people to eat any quicker just so you can get to the next person. The majority of the time staff are just doing what they can and moving on as they are too scared to spend too long with people."
● People were referred to outside agencies where they were identified as at risk of weight loss or poor diet and fluids. However, external recommendations had not always been followed to ensure people's intake improved. For example, where staff had been advised to encourage diet and fluids this had not happened to ensure people's risks reduced. This placed them at continued increased risk of harm.
● People's mealtime experience was poor and people were not treated with dignity around their needs at mealtimes. For example, people on pureed diets had their meals presented poorly and people requiring support at mealtimes were referred to as 'feeders' by staff.

Failing to ensure people received the support they required with their nutrition and hydration placed them at risk of harm. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care
● People had access to external health and social care professionals where they needed them. For example, where people had lost weight staff had referred them to the dietician. However, staff had not always followed professionals advise to stop people from losing further weight.
● When people experienced periods of anxiety or distress, staff referred them to community mental health services for further support.
● People were reviewed by the GP regularly within the home and staff shared information about people's conditions.

Adapting service, design, decoration to meet people's needs
● People were able to personalise their rooms to make them feel homely in line with their preferences.
● The provider had pictorial signage to support people to orientate themselves around the home.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

● Although we identified one instance when a Best Interest decision had not been documented in respect to a person's bed rails. Overall, the service was working within the principles of the Mental Capacity Act (MCA) and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● Documents confirmed that some mental capacity assessments had been undertaken. The outcome was highlighted as for example, 'capacity' confirmed.
● Some relatives told us they had power of attorney authorised licences to speak on behalf of their family member. They had given permission for their family member's COVID-19 and influenza vaccinations to be administered to prevent ill health.
● Staff confirmed they had completed MCA training and gave a good explanation of what unlawful restriction could be and how this did not comply with people's human rights.
● We observed staff asking people their permission before they carried out support tasks.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question as requires Improvement. At this inspection this key question has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Support delivered was not always personalised or in line with people's preferences. For example, people were not able to have a shower then they wished to. Relative and staff feedback confirmed this. One staff member told us, "People usually have a shower once a week because it all we can do. Some of them love to talk to you but you just don't have the time to give it them."
- People's preferred routines were not adhered to, as whether this was their preference or not, personal care was at times not provided until after lunch.
- There was limited evidence of people and those important to them where involved in their care planning and support. The regional managers told us they have just restarted 'the resident of the day' to review people's care and support with them. We will check this at our next inspection.

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 our last inspection we identified concerns in relation to people did not always have support to follow their interests and to take part in activities. At this inspection we found improvements had not been made. One person said, "It used to be good here; singers, art all sorts going on, this has stopped." A relative told us, "It does not seem like there are many activities and that is a shame."
- People did not have regular meaningful interactions with staff as they did not have the time. For example, over a 3-hour period, we observed 3 people in the first-floor lounge. During this time, apart from being offered a drink and being provided with lunch, there was little attention or engagement from staff and the same film played nearly 3 times.
- Notice boards throughout the home advertised the activities provided. However, there was only activity co-ordinator. In communal areas people slept or looked ahead. The managers on site told us that a second activity co-ordinator had been appointed and would start work soon enabling activities provision seven days a week.

Failing to ensure people had access to personalised care and support in line with their needs and preferences placed people at risk of harm. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

End of life care and support

- People being supported at the end of their lives had limited information around their wishes and preferences on this support. This placed people at risk of not receiving care in line with these.

We recommend the provider consider current best practice around supporting people at the end of their lives and take action to update their practice accordingly.

Improving care quality in response to complaints or concerns

● The provider had not improved care quality in response to complaints or concerns. The provider had a complaints policy in place. However, this had not always been followed to ensure people and their relatives received an outcome to any concerns raised in a timely way.

● One relative told us they had raised several issues weeks ago and had not received any feedback at all. They said, "The issues really upset our family, and no-one has the decency to tell us what they are doing about them." With the relative's permission we raised this issue immediately with the regional managers on site. They spoke with the family, logged the issues on the complaints system and gave the family assurance that the issues would be investigated.

● We saw some complaints had been made and the provider had responded to these. One relative told us, "I raised an issue about a staff member. Although I have not been told, I think it has been dealt with, as the staff member does not assist them (family member) now."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were assessed, and plans put in place to support people with this area of their care.

● People had information in their files to ensure staff knew how they communicated. Staff were able to tell us how people preferred to communicate.

● A regional manager told us information was available for people should they require it in their chosen format.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed to ensure there was sufficient and effective quality assurance and oversight at the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Managers and staff did not have a clear consistent understanding about quality performance requirements, risks and regulatory requirements. For example, the management team had completed an action plan to address concerns they had found. However, this had failed to identify and take immediate action to the concerns we found during our inspection. This placed people at continued risk of harm.
● Monthly reviews on people's care plans had failed to identify concerns we found. People did not have care plans and risk assessments in place where they experienced periods of anxiety and distress which meant there was a risk they would not receive consistent care in line with their needs.
● Daily reviews of people's diet and fluid intake and pressure care had failed to identify people consistently were not receiving adequate support with diet and fluids or pressure relief. This placed people at continued risk of harm.
● A review on staffing ratios had failed to identify there was not sufficient staff to meet people's needs in a safe way. This had placed people at risk of harm and had impacted on their dignity and lack of person centred care.
● Quality assurance tools had failed to identify people did not have access to personalised care and support in line with their needs and preferences. Whilst improvements were ongoing to activities within the home, this had been a continued concern on the previous 2 inspections and not enough improvement had been made at the time of our inspection to improve people's quality of life.
● Quality assurance tools had failed to identify people did not receive their wound care as required. This has resulted in a deterioration in people's wounds and skin condition.
● Quality assurance tools in relation to medicines, had failed to identify the concerns we found during this inspection around the storage and administration of medicines.
● Whilst permanent staff we spoke with understood their roles and responsibilities, it was not clear if all agency staff were briefed in relation to the individual needs of people and their specific responsibilities, such as male staff only providing care to female people where they had expressed their permission.
● Good care is the minimum that people receiving a service should expect and deserve to receive. The

service has been rated 'Requires Improvement' on nine consecutive inspections since 2014 when they registered with CQC. This was the home's fifth consecutive breach of regulation 17.

Systems had not been established to assess, monitor and mitigate the quality of care and support at the home. This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded following our inspection. Wider members of the management team developed an action plan to support the home to make immediate improvements to ensure people received care and support in line with their needs and there was leadership in place to oversee this.

● The interim managers had identified two incidents that we should have been notified about by law in order that we could check that appropriate action had been taken. However, once this shortfall was identified retrospective notifications had been made.
● The rating from the previous inspection was displayed in the home and on the provider's website in line with our requirements.

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.
● Duty of candour requirements were understood by the regional managers present. However, these were not always being met as the cause behind deterioration in people's health and wellbeing had not been shared with people and their relatives as this had not been identified prior to our inspection.

Working in partnership with others
● The service worked collaboratively with other agencies where people required additional support. However, advice given my other agencies around people's diet, fluid, pressure and wound care had not been followed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff we spoke with felt unsupported by the management team. One staff member told us, "With [the current management team] it's very hard to raise things as they push it back on you. it's like I am bringing you serious concerns and you are pushing it back on us like we are doing something wrong. We cannot cope up here with the staff. Nobody will listen."
● Staff felt they had no other option than to leave the service. One staff member told us, "I am only here a week, it's very hard we are on our third manager in the last 16 months. You are introduced to a new manager and then they hand their notice in too." Another staff member told us, "I am going to have to give it all up."
● Staff were pleased a pending staff meeting had been arranged where they would have the opportunity to raise concerns.
● Systems and processes were in place to gain the views of people and relatives through reviews and meetings. However, concerns raised by relatives were not always responded to in a timely way to enable them to have reassurances improvements had been made.
● Meetings had been re-started when the government lifted COVID- 19 restrictions. A relatives meeting had been planned and a staff meeting the day following our first day of inspection.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People had limited access to activities in line with their preferences. This was a continued concern from previous inspections. People did not have personalised care and support in line with their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not receive support with their diet and hydration in line with their care plans. People were losing weight as they had limited support from staff at mealtimes.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's care were not always managed adequately. People requiring support with their nutrition, hydration, pressure relief and wound care did not receive this as care planned.

The enforcement action we took:

We told the provider they needed to make improvements within specific timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance tools had failed to identify the improvements we found that were required at this inspection. Oversight at the service had not been effective at driving and embedding improvements. The provider remains rated as requires improvement for the ninth time.

The enforcement action we took:

We told the provider they needed to make improvements within specific timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff available for people to meet their needs in a safe and timely way.

The enforcement action we took:

We told the provider they needed to make improvements within specific timeframe.