Red Homes Healthcare Limited

Red Rose Care Community

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

Summary of findings

Overall summary

Red Rose Care Community is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up 65 people, including people living with dementia.

We inspected the home on 28 August and 3 September 2018. The first day of our inspection was unannounced. On the first day of our inspection there were 37 people living in the home. This was because in January 2018 the then registered provider placed a voluntary embargo on new admissions to the home. Additionally, following our inspection of May 2018 the local authority also placed an embargo on new admissions. The home is divided into three separate units (two on the ground floor and one on the first floor). However, at the time of our inspection the registered provider had closed the first floor unit to reflect the reduced occupancy level in the home and to facilitate the refurbishment of the unit.

We last inspected the home in May 2018 when we rated it as Inadequate and placed it into 'special measures'. In June 2018 we re-registered the home to reflect a change in ownership. This was our first inspection of the re-registered home. We were disappointed to find that the new owners had made no significant improvement in service quality. As a result, the overall rating of the re-registered home is also Inadequate and the home is therefore in special measures.

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

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was because of shortfalls in organisational governance; a failure to properly assess and mitigate risks to people's safety; a failure to ensure sufficient staffing to meet people's needs and to keep them safe; a failure to protect people's rights under the Mental Capacity Act 2005; a failure to ensure staff had the skills and knowledge to support people safely and effectively; a failure to promote people's privacy and dignity and a failure to support people in a consistently person-centred way and to meet their needs for mental and physical stimulation. We also found the registered provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 due to a failure to notify us of allegations of abuse of service users.

In other areas, the registered provider was also failing to provide people with the effective, caring and responsive service they were entitled to expect. Some care provision was task-centred and lacking in warmth. People's hydration requirements were not always met effectively. Staff did not always contact external healthcare providers in a timely way and the provider's response to people's concerns and complaints was inconsistent. Further work was required to establish a healthy organisational culture and more effective lines of management control.

We have taken action against the registered provider to ensure that they make the necessary improvements to become compliant with legal requirements. You can see what action we told the registered provider to take at the back of the full version of this report.

In some areas the registered provider was meeting people's needs.

Staff received regular supervision and told us they worked well together in a mutually supportive way. People were satisfied with the food they received and staff encouraged people to maintain their independence. Staff were aware of adult safeguarding procedures and there was some evidence of organisational learning from significant incidents. Staff recruitment was safe. Senior staff had recently taken action to give people and their relatives more opportunities to provide feedback about service provision.

There was no registered manager in post at the time of our inspection. However, the provider had appointed a new manager who was due to commence her role shortly after our inspection. In the meantime, the management of the home was being undertaken jointly by the provider's chief operating officer and quality director. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider') they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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.

Some people's medicines were not managed safely.

Some aspects of the premises and equipment were unsafe.

Systems to prevent and control infection were ineffective and unsafe.

There were insufficient staffing resources to meet people's needs.

The provider's approach to individual risk assessment was unsafe.

There was some evidence of organisational learning from significant incidents.

Staff were aware of adult safeguarding procedures.

Staff recruitment was safe.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the requisite skills and knowledge to support people safely and effectively.

People's rights under the Mental Capacity Act 2005 were not consistently protected.

People's hydration requirements were not always met safely and effectively.

Staff were not always prompt in seeking advice from external healthcare professionals.

Staff were provided with regular supervision.

People were satisfied with the food provided.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's rights to privacy and dignity was not consistently promoted.

Some care provision was task-centred and lacking in warmth.

Staff encouraged people to maintain their independence.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive sufficient physical and mental stimulation.

People were not supported consistently in a person-centred way.

Staff did not always follow the requirements of people's care plans.

The provider's response to people's concerns or complaints was inconsistent.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to monitor and audit the quality of service provision were ineffective.

The provider had failed to take action to address areas for improvement highlighted at previous inspections.

The provider had failed to notify CQC of issues involving people living in the home.

Action was required to establish a healthier organisational culture and more effective lines of management control.

Staff enjoyed their job and said they worked together in a mutually supportive way.

Action had been taken to give people and their relatives more opportunity to give feedback on the service.

Red Rose Care Community

Detailed findings

Background to this inspection

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

We visited Red Rose Care Community on 28 August and 3 September 2018. On the first day our team consisted of two inspectors, an assistant inspector, a specialist advisor whose specialism was nursing 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. On the second day three inspectors returned to complete the inspection.

Before our inspection visit we reviewed information we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams.

During our inspection we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with 13 people who lived in the home, five visiting family members, five members of the nursing and care staff team and the cook. We also spoke with the provider's chief operating officer and quality director who shared responsibility for the management of the home pending the arrival of a new manager.

We looked at a range of documents and written records including people's care files and staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Following our inspection visit, we reviewed additional documents we had requested from the provider including staff training records and information on Deprivation of Liberty Safeguards (DoLS) applications.

Inadequate

Is the service safe?

Our findings

At our last inspection of the home in May 2018, before the change of ownership, we found that the then registered provider had failed to properly assess and mitigate risks to people's safety. As a result, the provider was in continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we were disappointed to find that the new registered provider had failed to take sufficient action to address many of the shortfalls identified at our previous inspection.

We found the new provider was failing to store and administer people's medicines safely in line with good practice and national guidance. For example, in respect of storage, temperature records in one of the medicine storage rooms in the home indicated numerous occasions on which the room temperature had significantly exceeded the maximum recommended temperature of 25 degrees Celsius, increasing the risk to people's health from receiving unsafe or ineffective medicines. In the period 1 – 16 August 2018 the temperature had been recorded at 30.8 degrees on eight occasions and on three occasions at 34.9 degrees. There was no indication that this unsafe storage practice had been reported by the nursing staff who had recorded the temperature on each of these eleven occasions. When we raised this issue with the provider's quality director she told us, "No incident form was filled out. [The staff] didn't tell us."

When we looked at medicines administration practice we found no evidence that staff had administered one person's prescription eye drops on six occasions in the period 11 – 24 August, increasing the risk of permanent damage to the person's eyes. Talking to us on the first day of our inspection, another person's relative told us, "[Name] didn't have her drops in her eyes yesterday. [When this happens] her eyes dry up and get all sore. She needs them in the morning. They should do this first thing." Similarly, when we looked the medicine administration records for people who had been prescribed skin creams to prevent skin break down, we found numerous gaps. For example, for one person there were seven instances in the period 4 – 27 August where there was no record of staff having administered their prescription creams. For another person there were eight instances in the period 4 – 28 August 2018. For people who had been prescribed insulin the provider had no system in place to record the previous administration site, increasing the risk of reduced insulin absorption from using the same administration site on repeated occasions. Additionally, for people who had been prescribed a particular medicine that needed to be given 30 to 60 minutes before food and other medicines, the provider did not have consistent arrangements in place to ensure these specific administration instructions were followed.

We also found aspects of the provider's approach to infection prevention and control were ineffective and unsafe, creating an enhanced risk to people's health and welfare. For example, care staff told us that they put any soiled laundry in red bags which they then placed in a hopper in the laundry to await washing by the laundry staff. However, on the afternoon of the first day of our inspection we found towels soiled with faeces had been placed un-bagged in the hopper, increasing the risk of cross-contamination and infection. This risk was compounded by the fact that the laundry was only a few metres from the kitchen and, at the time we found the contaminated towels in the open hopper, neither the kitchen nor laundry room door was closed.

When we showed this hazard to the quality director she acknowledged, "It's not [good] infection prevention and control [practice]." Similarly, in one of the rooms used to store medicines and clinical equipment we found a suction machine which was available for use with people who experienced swallowing difficulties. The machine was stored on the floor, increasing the risk of infection to anyone on which it was subsequently used. Additionally, the quality director confirmed that the provider had no system in place to check the condition of the mattresses in the home, increasing the potential risk of health-care acquired infections resulting from damaged mattresses remaining in use.

We identified a number of concerns about the safety of the premises and the use of equipment in the home. The staff room was situated on a communal corridor which was used regularly by people living in the home, many of whom were living with dementia. On the first day of our inspection, the staff room was unlocked. Inside the room there was a table-top water boiler that staff could use to make hot drinks. The boiler was full of hot water, increasing the risk that a person could have injured themselves had they accessed the room via the unlocked door. When we highlighted this hazard to the quality director she told us, "The door should be locked. It's got a boiler in it." However, on the second day of our inspection we found the staff room door was still unlocked. As described above, a suction machine was available for staff to use in the care of people with swallowing difficulties, a number of whom were living in the home at the time of our inspection. However, on the first day of our inspection we found this important piece of equipment was not plugged in or charged ready for use, creating an enhanced risk to people's health were it to be required at short notice.

Some people who spent most or all of their time in bed had an electrically operated 'airflow' mattress which was used to help prevent the risk of skin damage. However, staff lacked knowledge of how to calibrate the mattresses to ensure they were at the correct setting for each person. For example, our inspector asked one of the nurses to confirm the correct setting for one person's mattress. The nurse looked at the mattress and saw it was set at 7.5. She adjusted the setting telling us, "The dial should be turned to 8." Asked how she knew 8 was the correct setting for this person, the nurse told us she was unsure and left the room. Our inspector then talked to a member of the care team about the same mattress. The staff member explained (correctly) that, "Everyone's mattress should be set to their weight. This person is a level 8." However, when asked how she knew the person's mattress should be set to level 8, the staff member told us, "Oh, I am not sure, we just set them to 8."

We also identified significant shortfalls in the availability and use of call bells in the home, presenting an enhanced risk to people's safety and welfare. For example, on the first day of our inspection we heard one person calling out for assistance. The person appeared distressed and was shouting, "Someone help me." Although this person had a call bell in their bedroom and was aware of how to use it, the call bell was out of their reach, limiting their ability to ask for assistance or reassurance when required. Following this incident, we found five other people did not have a call bell in their room. Another two people had a call bell but it was not within reach. When we discussed this issue with staff, one member of the care team told us, "They don't get buzzers because they lack capacity [to use them properly]." However, we found no evidence that the decisions to deprive people of a call bell had been taken in accordance with the requirements of the Mental Capacity Act 2005. On the second day of our inspection, we found some people were still without buzzers, including the person who had been calling out on the first day.

We looked at people's care records and saw that a range of possible risks to each person's safety and wellbeing had been considered and assessed. However, in some cases the preventive measures identified were not implemented properly, increasing the risk of harm. For example, one person had been assessed as being at risk of not drinking enough to stay healthy. Staff monitored the person's daily fluid intake but had not identified an individual 'fluid goal' for the person to ensure their fluid intake was sufficient. Acknowledging this unsafe practice, one member of the care team told us, "We should calculate how much

they weigh [and] then work out how much fluid they need. But we don't have time to do fluid goals for people. There's no time for anything. So we just get them to drink what we can." When we raised this concern with the quality director she said, "There should be targets on the hydration charts." We also found some people's risk assessments had not been reviewed and updated to take account of changes in their needs. For example, one person had been assessed as being at risk of falling with six falls recorded in the period 3 June – 10 August 2018. The person's 'moving and handling' care plan had not been reviewed following these falls and there was no evidence that any risk reduction strategies had been put in place or considered. Sadly, the person fell again on 15 August 2018, sustaining substantial facial bruising. Similarly, another person with a history of falling had five recorded falls in the period 7 July – 20 August 2018. Again, the person's care plan had not been reviewed following these falls and the only evidence of any additional preventive measures being implemented was after the person fell again on 21 August 2018, sustaining a head injury.

Taken together, the provider's failure to properly assess and mitigate these various risks to people's safety was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection of the home in May 2018, we found that the then registered provider had failed to ensure sufficient numbers of staff were available to meet people's needs. As a result, the provider was in continuing breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

At this inspection we were again disappointed to find that the new registered provider had failed to take effective action in this area and significant shortfalls remained.

People we spoke with told us there were often insufficient care staff available to meet their physical care and support needs. For example, one person's relative said, "[Staff] have a lot to do which means they can't do everything." Another relative commented, "I am concerned there are not enough [care staff]. [People] are just left on their own for a long while." One person told us, "I think everyone could do with a bit more help." Reflecting this feedback, on the morning of the first day of our inspection, we saw one member of staff put a cup of tea on a table beside a person who was sitting in one of the communal lounges. The person could not drink unaided and the staff member said, "I'll come and help you with it in a minute." This staff member never returned. Some 37 minutes later another member of staff helped the person drink their tea, by which time it was almost cold. Similarly, we observed one member of staff ask their colleagues for assistance to transfer a person from their wheelchair to an armchair. No one was free to assist and, as a result, the person remained in their wheelchair for a further 55 minutes.

At lunchtime on the first day of our inspection we saw one member of staff supporting someone to eat their meal. However, there were no other staff in the dining room and the staff member had to repeatedly leave the person to support other people. As a result, the person kept falling asleep and had be woken up to continue their meal each time the staff member returned. Talking about care staffing levels in the home and the many pressures on their time, one member of the care team told us, "We need more staff. [We have to] update care plans, reposition people, assist them to eat, write down what they have eaten. How do we do [all] that? Who … suffer[s]. Just the residents." One of the nursing staff told us, "There just isn't enough staff. Most residents require two staff for each intervention and 11 residents require assistance at mealtimes. The [care] staff are run ragged and ... are demoralised."

People also told us that staff did not have enough time to meet their emotional needs. For example, one person said, "I have no one I can really talk to here. Staff…. don't have the time." Another person's relative

commented, "There is nothing going on here. People are lonely and bored." One member of the care staff team told us, "I'd like to dance with them. [But] you think I have time to dance with them? I am too busy changing pads." Another staff member commented, "[We] could do more with them if we had more staff." Reflecting this feedback, on both days of our inspection we saw people sitting for long periods of time with no stimulation or occupation and only occasional, fleeting interactions from passing staff.

People also expressed their concerns that staffing resources were insufficient to ensure people were properly supervised and kept safe from harm. For example, one relative commented, "I worry that [name] isn't safe here [due] to the staffing levels. [Name] has had a number of falls here. But it is never clear what happened. They always say nobody saw it." Another relative told us, "[Name] was pushed over in the corridor by another resident and was taken to hospital where she was treated for a nasty gash on the back of her head. That was about three weeks ago." In confirmation of these comments, throughout our inspection, we saw people living with dementia were often left for extended periods without staff support or supervision. For example, on the first day of our inspection we saw one person walking repetitively around the home on their own. The person had a shawl on her shoulders which was trailing on the floor, creating a potential trip hazard. Another person also walked repetitively around the home. On two occasions this person entered another person's bedroom causing the person in the bedroom to become agitated. We saw another person walking down a corridor pushing a wooden dining chair along the lino floor. Despite the hazard this presented to the person and others, we saw several staff members pass by without reacting. Talking specifically about the issue of unwitnessed falls, some of which are detailed above, one staff member told us, "Falls? It is because we are elsewhere [in the home] assisting people [with personal care] or repositioning. We turn away and they are on the floor. Sometimes when you come back in from a day off [a colleague] will say, "So and so fell yesterday. We were short, doing something else'."

When we discussed staffing levels with the quality director she told us that she used a 'dependency tool' to identify the correct staffing levels to meet people's needs. She also said that she thought the current care staffing level was "fine". However, despite this assurance it was clear from the feedback from people, visitors and staff and our observations throughout our inspection that care staffing levels were not "fine" and were in reality insufficient to meet people's physical and emotional support needs and to keep them safe. Furthermore, when we reviewed the care staffing rosters for the period 4 – 27 August 2018 we saw there were seven occasions when the actual number of care staff in the home was less than the number rostered to be there. Commenting on a recent episode of short staffing one member of the care team told us, "Last week we were running [with one care assistant down] all day. We don't like it … [it's] all a …. bit harder."

The provider's failure to ensure sufficient staffing to meet people's needs and keep them safe was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

More positively, staff understood adult safeguarding procedures and were aware of how to report any concerns relating to people's welfare, including how to contact the local authority or CQC, should this ever be necessary. We reviewed staff recruitment practice and found that this was safe. For example, pre-employment checks had been completed correctly to ensure that any new recruits were suitable to work with the people who used the service.

We also found some evidence that the new provider had begun to introduce a culture of organisational learning within the home. The chief operating officer told us, "There was a blame culture previously. Staff were not able to talk freely." Supporting this analysis, the quality director added, "We are becoming much more reflective. Looking back incidents [to] identify if we need to do anything differently." Although both these senior managers acknowledged that further work was required to fully embed this approach, it was heartening when a member of the care team told us, "[The quality director] wants us to learn when we have

made a mistake. They won't tell you off but take it as a learning curve."

Inadequate

Is the service effective?

Our findings

At our last inspection of the home in May 2018, we found that the then registered provider had failed to ensure staff had the skills, knowledge, experience, training and support to fulfil their job roles competently. This was a continuing breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the new provider had failed to take sufficient action in this area and significant shortfalls remained.

The provider maintained a record of each staff member's mandatory training requirements and organised a range of courses to meet these needs. The quality director told us that, since our last inspection, the hours of the provider's in-house trainer had been increased to full-time to improve training provision and ensure staff received their mandatory training within the required timescale. Talking positively of this initiative, the quality director told us, "We have made big changes [to staff training]. We were struggling to get staff to training [and they] were falling through the cracks. [Now] training is much improved. When you look at the training matrix you will find a lot less red [gaps in training] than there was." The quality director also said that the arrangements for the induction of new staff had been improved. She told us, "[New starters] have two days [induction training] with [the trainer] and then they have to work two supernumerary shifts. [The trainer] introduces them to [the other staff] and guides them. She also [oversees] the implementation of the Care Certificate. We've a lot working towards it." The Care Certificate sets out common induction standards for social care staff.

However, despite this upbeat assessment of the provider's approach to staff training and induction, when we reviewed the provider's training records, we found significant backlogs remained in some of the training courses the provider deemed mandatory for all care staff. For example (excluding very recent starters and staff on maternity leave), the training matrix indicated 11 care staff (26%) had not completed the provider's 'first aid – basic life support' training course and a further seven had not undertaken it in the three years preceding our inspection, increasing the risk that their knowledge was out of date. One member of staff had not undertaken this training since January 2012. Similarly, three members of staff had not completed the provider's 'health and safety' training course and a further six had not undertaken it in the previous three years. One member of staff had not undertaken this training since June 2010. Most worryingly of all, five members of staff had not completed the provider's 'moving and handling' course, including one care assistant who had been in post since April 2018 and another who had been in post since May 2018. A further five members of staff had not undertaken the training in the previous three years.

We found a similar pattern when we reviewed the provider's record of 'non-compulsory' training provision. For instance, only 11 members of the care team had received 'challenging behaviour' training and this had all been delivered in 2012 or before. Similarly, 21 care staff had not completed either of the provider's 'mental health and dementia' or 'dementia matters' courses, despite the significant number of people in the home who were living with dementia, some of whom could be challenging to support.

Reflecting some of the shortfalls in the provision of mandatory and other training, throughout our inspection we observed staff lacked some of the skills and knowledge required to care for people safely and effectively. As described in the Safe section of this report, staff did not always store soiled laundry in line with good infection control practice and some staff did not understand how to set up air flow mattresses correctly. Additionally, on the first day of our inspection we watched two members of the care staff team using a hoist to transfer a person from an electrically operated recliner chair to their wheelchair. Whilst the person was suspended in mid-air, one of the legs of the hoist became trapped on the cable for the recliner remote control. Rather than lower the person down back down to enable the cable to be removed safely, one of the care staff knelt down and lifted the leg of the hoist over the cable. As a result of this unsafe practice, the hoist jolted causing alarm and stress to the person being transferred. On another occasion we watched a member of staff supporting a person to stand out of their wheelchair without putting the brakes on first, increasing the chance of an accident. On two occasions, we saw staff assisting people who were living with dementia to go to the toilet. On each occasion, a staff member said, "Come with me, I've got a surprise for you." This was an approach that would be likely to confuse and distress a person living with dementia, indicating a lack of understanding in how to support people living with dementia effectively. When we alerted senior staff to this issue the chief operating officer said, "It's totally inappropriate." The quality director added, "There is clearly work to do with our staff."

The provider's failure to ensure staff had the skills and knowledge to support people safely and effectively was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of the home in May 2018, we found that the then registered provider had failed to provide care in line with the principles of the Mental Capacity Act 2005 (MCA). This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we again found that the new provider had failed to take sufficient action to improve service provision in this area and significant shortfalls remained.

Care staff were aware of the MCA and understood the importance of obtaining consent before providing care or support. The 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. Describing their approach in this area, one member of the care team said, "It was covered in my induction. It's all about [offering] choice. What they like to wear. Or eat or drink. You can't force them."

Senior staff made use of best interests decision-making processes to support people who had lost capacity to make some significant decisions for themselves. However, we found some best interest decisions had been made incorrectly and, as a result, people had been deprived of their rights under the MCA. For example, as described in the Safe section of this report we found no evidence to indicate the decisions to remove call bells from people because they lacked the capacity to use them properly had been taken in accordance with the requirements of the MCA. Additionally, the relative of one person who lacked capacity to make some decisions for themselves had been granted a 'lasting power of attorney' (LPA) authorising them to make decisions on the person's behalf. Senior staff had taken a number of decisions as being in the person's best interests including decisions to administer medicines covertly in food (without the person's knowledge) and to fit safety rails to the person's bed. Staff were aware that the person had a relative with an LPA who therefore had the legal right to make these decisions on behalf of the person. However, there was no evidence that the relative had been involved in these decisions. Senior staff had assessed another person

as lacking capacity to make significant decisions for themselves. Staff had taken a number of decisions as being in the person's interests which were documented in the person's care record. However, for a decision taken in January 2018 to fit rails to the person's bed, there was no evidence that staff had taken this significant decision in accordance with the requirements of the MCA. Speaking candidly about this issue, the quality director acknowledged, "Bed rails risk assessments are all in place. But consent is not in place for everyone as [we have] not got round to it." More generally, we found the quality of the best interests decision forms we reviewed was poor, with the use of standard phrases which appeared to have been cut and pasted from one form to another with no attempt to tailor the content to the particular decision under consideration or the person's individual situation.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). During our inspection, senior staff were unable to provide a definitive record of the DoLS that had been authorised for people living in the home or the applications that been submitted. For example, one of the nurses told us that DoLS applications for four people had been made in May 2018. Asked if these had been authorised, the nurse said, "It's not been followed up. I am unsure if they are in place." In respect of another application the nurse told us, "There is no paperwork in the folder [but] she had [an assessment] on 10 May so she must have it." Additionally, some DoLS that had been authorised had expired and the provider had not submitted a reapplication or this had been done late. For example, one DoLS authorisation had expired on 1 August 2018 but the reapplication had not been sent until 24 August. Another DoLS authorisation expired on 6 August 2018 and on the first day of our inspection on 28 August the reapplication had still not been submitted.

We reviewed some of the DoLS which had been authorised and identified a number of concerns. For example, one DoLS had been authorised on 22 June 2018 subject to six conditions. However, several of these conditions had not been met by the provider, some two months later. For instance, one condition required the provider to make an "immediate" referral for the person to be assessed by an occupational therapist. There was no evidence that this had been done. Similarly, another condition stated that a formal best interests decision was required to support the continuing use of bed rails. Again, although bed rails were still in use, there was no evidence that a legally-compliant best interests decision had been taken. Another DoLS had been submitted and authorised when the person was fully mobile and did not require the use of bed rails. The person's mobility had subsequently reduced and they now spent most of their time in bed with bed rails in place. The introduction of bed rails should have resulted in another DoLS application but there was no evidence that this had been done.

The provider's failure to ensure people's rights under the MCA were not fully protected was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although most people we spoke with told us they were happy with the food provided in the home, we identified some concerns about the provision of drinks. On the morning of the first day of our inspection, we saw four people sitting in one of the communal lounges. One had a glass of juice but the others had none, increasing the risk of dehydration. Describing the situation, one person told us, "We've got no drinks in here. Nothing." Some people who spent most of their time in bed had been provided with juice and tea or coffee but had not been supported to drink them, again increasing the risk of hydration. At lunchtime on the first day of our inspection, one relative told us, "[Name] has a full beaker of tea, cold on the table [in their bedroom]. A beaker of blackcurrant with the same amount [of juice in it] as [when I came in] morning. And a jug still full with blackcurrant." Taken together with our concerns about the lack of hydration 'goal' sheets described in the Safe section of this report, it was clear improvement was required to ensure people's hydration requirements were met safe and effectively.

As described above, most people said they were satisfied with the food provided in the home. For example, one person told us, "The food is good. I really like the breakfasts here." People were offered a full range of cooked and continental options at breakfast. The cook told us, "[Name] always has a cooked breakfast. Toast, egg and beans. Plenty of beans!" For lunch and tea, people made their menu choices a day in advance. For example, at 10.30am on the first day of our inspection we saw a member of staff asking people what they would like for lunch and tea the following day. Although no one raised this as a concern, many people living in the home had a degree of memory loss and would have found it difficult to remember what they had ordered, more than 24 hours earlier. Aware of this issue, the cook told us, "There is a menu on the table [to remind people] and if they change their mind I can [make] something they like. Such as an omelette or a jacket potato rather than [the main menu option]." Kitchen staff understood people's likes and dislikes and used this to guide them in their menu planning and meal preparation. For example, the cook told us she had recently started offering people fresh fruit on a daily basis. Describing this initiative, she told us, "I put fresh fruit in little pots on the tea trolley. Blueberries, melon, raspberries." During our inspection we saw several people enjoying this alternative to biscuits. The cook was also aware of people's individual nutritional requirements, for instance people who needed their food pureed to reduce the risk of choking.

From talking to people and looking at their care records, we found that staff were generally proactive in seeking the support of external professionals when this was required. For example, GPs, mental health professionals and specialist nurses. However, as described above, the provider had failed to seek occupational therapy input for one person, despite this being a condition of the DoLS authorised for that person. Further work was therefore required to ensure a consistently effective approach in this area.

More positively, staff from the various departments within the home told us they worked closely together to meet people's needs as effectively as possible. For example, talking positively of their relationship with the nursing staff, one recently recruited member of the care team told us, "The nurses are all lovely. They are hands on, all of them. I was quite surprised how they mix in. They don't make you feel like they are the nurse."

Staff received regular supervision from senior staff. Talking about a recent supervision, one recently recruited member of staff told us, "I had it with [name of one of the nurses]. She's lovely. She asked me how I was getting on."

The provider had recently introduced a new online resource to give staff easier access to internal policies and procedures and external best practice guidance. Staff spoke positively of this initiative. For example, one member of the nursing team told us, "I regularly go on it."

The chief operating officer advised us that the new provider had started to take action to improve the physical environment and equipment in the home to ensure they remained suitable for people's needs. She told us, "There had not been investment for some time. But curtains, duvets and mattress toppers [have all been] ordered. To lift the place." The quality director told us that new vanity units had been ordered for people's bedrooms and that vinyl floor coverings were being installed in bedrooms and communal bathrooms to improve infection control. The provider was also in the process of refurbishing the vacant upstairs unit in the home and action was in hand to further enhance the suitability of the environment for people living with dementia. For example, by providing each person with an individual 'memory box', to make it easier for them to find their way to their bedroom.

Requires Improvement

Is the service caring?

Our findings

At our last inspection of the home in May 2018, we found that the then registered provider had failed to ensure care and support was provided in ways that promoted people's dignity and privacy and provided people with sufficient respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

At this inspection we were disappointed to find that the new provider had failed to take sufficient action to improve service provision in this area and significant shortfalls remained.

The provider's 'service user guide' which was given to people when they first moved into the home stated, 'We … value each and every individual who comes to live at Red Rose. All residents … will be treated with respect and dignity."

Staff told us that they understood this commitment to supporting people in ways that helped maintain their dignity and respect. However, during our inspection we found that this was not reflected consistently in their practice. As described in the Effective section of our report, we witnessed some staff engaging with people living with dementia in a disrespectful way. Additionally, when talking to our inspection team, some staff described people in very undignified and impersonal ways as "feeds" (people who needed support to eat) or "softs" (people at risk of choking). This was despite staff being aware that they should not be using these terms. For example, immediately after telling one of our inspectors about the support they gave to the "feeds", one member of staff said, "Sorry, I shouldn't say that." Staff also used old-fashioned, institutional terminology to describe the home. For example, some described the living units in the home as a "ward".

Staff also told us that they understood the importance of supporting people in ways that respected their privacy. Again however, we found this commitment was not reflected consistently in their practice. For example, one member of staff openly acknowledged that they did not always knock on people's bedroom door before entering. Talking about this breach of people's right to privacy one staff member said, "Sometimes we just walk in. It's just the rush. The mentality of having to get things done. [We] go on autopilot. It goes back to the staffing." Additionally, in one of the units of the home, people's care documentation was kept in an open plan 'care station' in a corner of the dining room. The care station was often left unattended meaning people's private, confidential information could be accessed by people and visitors using the dining room. One relative told us, "[My relative]'s care plan was left on a chair the other day. The carer was writing in the care plans and got called away." Furthermore, staff using the telephone in the open plan care station could be overhead by anyone sitting in the dining room when they were making healthcare appointments for people and discussing other confidential issues with external professionals.

The provider's failure to protect people's right to privacy and promote people's dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

Most of the people we spoke with told us that staff were caring and kind in their approach. For example, one person said, "They are very good to me." Another person told us, "They are kind to me." Staff also told us

that they understood the importance of caring for people with compassion but during our inspection we found this commitment was not reflected consistently in their practice. We saw some staff interacting with people in a caring way. However, at other times, the provider's failure to provide sufficient staffing meant care was task-centred and lacking in warmth. For example, on one occasion we watched two members of staff support a person transfer from their wheelchair to an armchair. Throughout this procedure neither staff member interacted with the person other than to issue instructions such as "lean forward" and "put your hands here". On another occasion we watched a member of staff pull someone back in their wheelchair without warning. We saw one person wearing trousers that were too big and which they held up to prevent them falling down. This went unnoticed by staff.

The quality director was aware of local lay advocacy services. Lay advocacy services are independent of the provider and the local authority and can support people to make and communicate their wishes. The quality director told us some people living in the home already benefitted from the input of an advocate and that she would not hesitate to help others to obtain similar support, should this be required in the future. Some people had relatives who helped them communicate their wishes. The relatives we spoke with had mixed views on the provider's approach to involving them in this way. One relative told us, "I have been involved from the word go because I insist on it." But another relative said, "Staff have contacted me to come to a meeting [at] 6pm [which] is difficult."

More positively, people told us that staff respected their independence. For example, one person said, "I please myself where I want to be. Sometimes I have a doze in my room and sometimes I come into the lounge." Another person said, "You can go to your room if you want to." Describing their approach to promoting independence in personal care, one staff member told us, "I try to keep them as active as I can. For instance, encouraging people to wash their face for themselves, if they are able."

Inadequate

Is the service responsive?

Our findings

At our last inspection of the home in May 2018, we found that the then registered provider had failed to ensure that people received a service that was centred on them and that met their needs, preferences and provided social stimulation. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

At this inspection we were disappointed to find that the new provider had failed to take sufficient action to ensure people were supported consistently in a person-centred way. During our inspection, as described in the Safe and Caring sections of this report, we observed several occasions when the many pressures on staff time resulted in people receiving rushed, task-centred care. Additionally, people told us of other ways in which staff support failed to take account of their individual needs and preferences. For example, one person told us, "I am quite capable of [managing my own medicines] but they insist [on doing it for me]." When we raised this issue with the quality director she confirmed that the person was capable of self-medicating and that she would look into the issue further. Another person's relative told us, "They have moved another resident down here … who screams and shouts all day. It distresses my relative who then becomes anxious. I have spoken to the manager about it and all she says is, 'Well just shut the bedroom door'. That's not helpful at all. I turn the radio up as loud as I can to try and drown out the noise." In another person's care file we found entries made by their relatives on 25 and 26 August 2018 recording that they had had to give the person their top teeth, glasses and hearing aid as they did not have them when they arrived at the start of their visit. Similarly, on the first day of our inspection we observed that staff only noticed at 12 noon that another person had been sitting in one of the lounges for some time without their glasses. When we looked at the provider's record of training we saw that the provider had designated 'person centred care' training as 'non-compulsory'. As a result, almost half the care staff team had not undertaken this training, depriving them of an opportunity to gain further skills and knowledge in this area.

The quality director told us that she had recently facilitated a review of people's care plans to ensure they reflected people's needs. Speaking frankly she said, "I found … the care plans … had been left [and] not evaluated for months. Changes to needs had not been updated. [To undertake the review] the nurses and seniors [were each] given about three people's plans to [update]. We've only got four left that need doing, out of thirty odd." However, despite this initiative, when we reviewed some of the care plans that had been updated we found these remained out of date in places. For example, one person's 'social' care plan which was dated 2 July 2018 stated that the person needed to spend most of their time in communal areas to address the risk of social isolation. However, from 20 July 2018 the person started to stay in bed throughout the day, reflecting a deterioration in their health. This significant change was not reflected in the social care plan nor was there any guidance on how the increased risk of social isolation was to be addressed. Commenting on the effectiveness of the care plan review process initiated by the quality director, a member of the nursing team said of one person's care plan, "Oh [that one] won't be any good because [name of a colleague] is doing it."

We also found the guidance set out in people's care plans was not always reflected in the care people received. For example, one person's 'communication and mental health' care plan stated, 'Staff may be

required to distract [name] on a one-to-one basis by engaging [name] in [talking] about [their previous employment and hobby]. These [interventions] should be reported in [the person's] behaviour chart'. However, when we reviewed this person's 'behaviour chart' we found no evidence that the recommended intervention had been deployed when the person became distressed. Similarly, in another person's care plan it stated, 'I like to be called [name]'. However, throughout the person's daily care record, staff had used a different name to describe them.

As detailed in the Safe section of this report, care staff told us that the need to prioritise physical care tasks left them with little time to provide people with emotional support or to respond to their need for physical and mental stimulation. The provider had employed an activities coordinator to take the lead in this area but they had recently left and had not yet been replaced. In the interim the quality director told us, "We are trying to get our [care] staff to help us out." However, care staff told us they did not have time for this additional responsibility. For instance, one member of the care team said, "We don't have time for social interaction. You can tell they are bored. I [sometimes] try to have a dance to give them a bit of giggle. But before I know it I've been called away to turn someone." People and their relatives also shared their dissatisfaction with the level of physical and mental stimulation available to them in the home. For example, one person told us, "I don't like it here. I am lonely and bored. Nobody bothers with me at all." Another person's relative said, "There is nothing going on here. [Staff] haven't got time to do anything except what is absolutely necessary." We raised this lack of stimulation and the negative impact it had on people's health and happiness with the quality director. She acknowledged, "There are not always enough care staff to provide sufficient stimulation." Although the provider had booked professional singers and other entertainers to visit the home, these were relatively infrequent events and throughout both days of our inspection we saw people sitting for long periods of time without any stimulation. Expressing their frustration and concern, one relative told us, "[Name] spends most of his time just sitting in the chair in his room. He needs mental stimulation but there is nothing. The staff don't even have time to have a chat with him."

Taken together, the provider's failure to support people in a consistently person-centred way and to meet their needs for mental and physical stimulation was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

Information on how to raise a concern or complaint was included in the information booklet that was given to people when they first moved into the home. People had mixed views on the provider's response to any complaint or concern they had raised. For example, one relative who had raised a complaint concerning the décor in their relative's bedroom told us they were satisfied with the provider's response. However, another relative told us, "I've got a number of issues I am not happy about [but] just get fobbed off." The provider maintained a log of any formal complaints which had been received. However, when we reviewed the log we found no evidence to indicate that two recent complaints had been acknowledged or investigated in accordance with the provider's policy. Additionally, correspondence relating to another complaint indicated a senior member of staff had taken over a week to ring the complainant to discuss their concerns about a serious injury sustained by their relative, despite having promised to do this straightaway. Further improvement was required to ensure people's complaints and concerns were managed in consistently responsive way.

The quality director told us that as people neared the end of their life, their care plan was updated to reflect their need to be pain free and comfortable. Looking ahead, she also said the provider was planning to create a specialist end-of-life service as part of the refurbished first floor facilities.

Senior staff were unaware of the new national Accessible Information Standard (AIS) which provides best

practice guidance in communicating with people in ways that meet their individual needs and preferences. However, the quality director told us she would research the AIS and incorporate into the provider's approach in the future.

Inadequate

Is the service well-led?

Our findings

At our last inspection in May 2018 we found shortfalls in organisational governance including a failure by the then registered provider to effectively operate systems and processes to assess, monitor and improve services and to reduce risks to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we were disappointed to find the new provider had failed to take sufficient action to improve the auditing and monitoring of service quality. For example, although regular care plan reviews and medicine, health and safety and infection control audits were conducted by senior staff, they had failed to pick up the shortfalls in premises and equipment, individual risk assessment, infection control practice and the management of people's medicines we identified on our inspection. Talking about the continuing shortfalls in the provider's approach to auditing service provision, the quality director told us, "We need to adapt our audits to focus on practice, not just environment." Additionally, despite the quality director openly acknowledging that she was aware that care staffing levels were insufficient to meet people's needs for physical and mental stimulation, the provider had taken no action to provide more staff. Similarly, there was no evidence to indicate the provider had taken action to address the short-staffing on the care rota, despite this having occurred frequently in the weeks preceding our inspection.

The new provider had also failed to make any significant improvement in the areas of concern identified at our previous inspection of the home. Despite having prepared an internal action plan, as described in the Safe, Effective, Caring and Responsive sections of this report, all of the breaches of regulations identified at our last inspection were also found at this inspection reflecting the new provider's failure to provide sufficient staffing to meet people's needs; to manage people's medicines safely; to maintain effective systems of infection control and infection; to protect people from a range of risks to their personal safety, including the risk of falling; to identify potential safety hazards within the building; to protect people's rights under the MCA; to ensure staff had the requisite knowledge and skills; to promote people's dignity and right to privacy; to respond to people's individual needs and wishes and to provide people with sufficient stimulation and occupation. Additionally, as detailed throughout this report, shortfalls in organisational governance had also contributed to issues of concern in other areas including engagement with external healthcare professionals; ensuring people were sufficiently hydrated; task-centred care practice and complaints management. At our last inspection of the previously registered service we rated it as Inadequate. At this first inspection of the newly registered service we found no significant improvement and people were still not receiving the safe, effective, caring or responsive service they were entitled to expect.

Taken together, the provider's failure to effectively assess, monitor and improve the quality of the service and to take action to address and mitigate a range of risks to people's health, safety and well-being was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in May 2018 we found the then registered provider had failed to notify us of allegations of abuse relating to people living in the home, as required by the law. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

In preparing for this inspection, we reviewed the notifications we had received since 21 June 2018 when the home was re-registered under the new owner. We found that during this period the new provider had also failed to notify us of two allegations of abuse relating to people living in the home which had been considered by the local authority under its adult safeguarding procedures.

The provider's failure to notify CQC of allegations of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was no registered manager in post at the time of our inspection. Following our May 2018 inspection of the previously registered service, the then registered manager stepped down and returned to a nursing role within the home. The new provider had subsequently appointed a manager who was due to commence her role shortly after our inspection. In the meantime, the management of the home was being undertaken jointly by the provider's chief operating officer and quality director who, between them, were based in the home from Monday to Friday each week. Reflecting these recent changes, some people expressed their concerns about the management of the home. For example, one person's relative told us, "There is such a lack of team leadership from anyone. Management change[s] all the time. They need a manager who walks the walk as well as talking the talk." Another person's relative said, "We don't know who is in charge now. They stay in their offices." One person commented, "I wouldn't recommend [the home] at the moment."

To their credit, throughout our inspection both the quality director and the chief operating officer displayed an admirably candid and non-defensive leadership style. Describing her approach, the quality director told us, "I have nothing to hide." Both senior managers told us that they were committed to creating a more open organisational culture and to addressing the many areas for improvement identified by CQC and other agencies. However, despite these aspirations, we found both these senior staff lacked insight into the reality of the service people were receiving. For example, at the start of our inspection, the quality director told us, "I do feel things are improving. I am confident you will find things are better than in May. It's not as bad as before." However, as described above, we found no evidence of significant improvement since the May inspection and found all of the same regulatory breaches as at that inspection. Similarly, as described throughout this report, we found a disconnect between senior staff's expectations of the staff under their control and the reality of their practice. For example, the failure of staff to adhere to the provider's infection prevention and control procedures; the continuing use of disrespectful terminology despite being told that this must stop and the repeated failure to lock the staff room door to protect people from the safety hazards within. Acknowledging that further work was required to establish a healthy organisational culture and more effective lines of management control, the chief operating officer acknowledged, "We desperately need to change staff attitudes."

More positively, despite their concerns about staffing levels, staff told us that they enjoyed their job and worked together in a mutually supportive way. For example, one staff member told us, "I do enjoy my job. The [other] staff are so friendly. They have been lovely to me. And [the chief operating officer and quality director] definitely listen to you. [I see them] on the floor." Another staff member said, "There have been ups and downs [but] I do enjoy working here … looking after the residents. That's all that matters to me. [And senior managers] do take our criticisms on board." Team meetings, daily logs and shift handover sessions were used to facilitate internal communication. One member of staff talked positively of their experience of attending a recent staff meeting. They told us, "It was about two weeks ago. [One of the directors of the registered provider] was there. He told us all about the [refurbishment] upstairs."

To help promote a culture of continuous quality improvement, the quality director and chief operating officer told us they had recently taken action to create more opportunities for people and their relatives to provide feedback on the service. Describing this initiative, the quality director said, "We are trying lots of

different ways of communicating. We [hold] formal relatives and residents' meetings at 6pm. [Although] they are well attended …. [some] relatives didn't want to come out in the evening [so we are also hosting] informal coffee mornings. On 13 September [we are also hosting] a meeting between residents and relatives and the chef." Talking positively about the most recent coffee morning one person said, "It was nice, all the staff were there." In another initiative to give people more involvement in the running of the home, one person had attended a recent staff meeting. The quality director told us this had been a positive experience for both the person and staff and that it would continue in the future.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered provider's failure to notify us of allegations of abuse of service users.

The enforcement action we took:

We fined the registered provider £1250.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person's failure to support people in a consistently person-centred way and to meet their needs for mental and physical stimulation.

The enforcement action we took:

We imposed an additional condition of registration to prevent the admission of any new service users without the prior permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person's failure to promote people's privacy and dignity.

The enforcement action we took:

We imposed an additional condition of registration to prevent the admission of any new service users without the prior permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered provider's failure to protect people's rights under the Mental Capacity Act 2005.

The enforcement action we took:

We imposed an additional condition of registration to prevent the admission of any new service user

without the prior permission of CQC.

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 The registered provider's failure to properly assess and mitigate risks to people's safety.

The enforcement action we took:

We imposed an additional condition of registration to prevent the admission of any new service users without the prior permission of CQC.

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 Shortfalls in organisational governance.

The enforcement action we took:

We imposed an additional condition of registration to prevent the admission of any new service users without the prior permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider's failure to ensure sufficient staffing to meet people's needs and to keep them safe. And the registered provider's failure to ensure staff had the skills and knowledge to support people safely and effectively.

The enforcement action we took:

We imposed an additional condition of registration to prevent the admission of any new service user without the prior permission of CQC.