

Keats House Healthcare Limited

Keep Hill Residential Home

Inspection report

17 Keep Hill Drive
High Wycombe
Buckinghamshire
HP11 1DU

Tel: 01494528627
Website: www.KeepHill.co.uk

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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?	Requires Improvement 
Is the service well-led?	Inadequate 

Summary of findings

Overall summary

About the service

Keep Hill is a residential care home registered to provide personal care and accommodation to nine people over 65. However, at the time of the inspection the service was providing care to a person under 65. The Statement of Purpose had not been updated to reflect the change in the service user band and we were not notified accordingly of the change in the service user band.

The service is owned and managed by an individual and is one of two homes run by the same provider.

At the time of the inspection nine people were living at the service. People's bedrooms were both on the ground and first floor. Five bedrooms have en-suite facilities and four people share shower rooms. People have access to communal facilities of the sitting /dining room.

People's experience of using this service and what we found

A person told us their experience of living at the service was "okay". Another person told us they hated it, felt disliked and had nothing in common with the people living there. A relative was happy with the care their family member received, although acknowledged the service looked "tired".

Safe care and treatment was not provided. People were not safeguarded from abuse and risks to them were not managed. Safe medicines practices were not promoted. Accident and incidents were not appropriately managed and there was no system in place to learn from incidents and prevent reoccurrence.

The staffing levels were not sufficient to ensure staff were not working excessive hours and changes in people's needs had not resulted in a review of the staffing levels. Staff were trained but the training was not effective to enable them to deliver safe and effective care. Staff were not supported in line with the provider's policy and daily practices were not monitored and poor practice was not addressed.

The environment of the service was not fit for purpose. The service was not suitably maintained and furniture and furnishings were broken, and unhygienic. People were assessed but the assessment failed to identify their needs and how they could be met. Person centred care was not provided and people's communication needs were not identified and met. Activities were provided but access to community-based activities was limited. The service had not established community links to benefit people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's privacy and dignity was not consistently upheld.

People's health and nutritional needs were identified but records were not suitably maintained to show how these were met. Records were not suitably maintained or secure.

The service was not effectively managed or audited. The registered manager failed to make the required notifications to CQC to inform us of events and changes within the service. They failed to bring about the required improvements to the service and had not identified other improvements were required.

The service had a consistent staff team and they knew people well. Some staff were generally kind and caring but their engagement with people was not always appropriate and show the required level of respect.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)

The last rating for this service was requires improvement (published 14 February 2019). The service has been rated requires improvement for the last four consecutive inspections. At this inspection the rating had deteriorated further.

The provider has been in continued breach of Regulation 17 for the past three inspections and in breach of Regulation 12 for two inspections, in 2016 and 2019. At the previous inspection in February 2019 positive conditions were imposed on the providers registration in respect of breach of Regulations 17. The provider/registered manager sent us monthly updates on the progress within the service, which was an overview of what had taken place in the service each month. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

Enforcement

We have identified breaches in relation to the management of risks, medicines, staffing levels and their training and support, the environment, level of cleanliness, consent, dignity and respect, person centred care, records, governance and notifications.

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

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate ●

Keep Hill Residential Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection was carried out by an inspection manager and an inspector on day one and the same inspector on day two.

Service and service type

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also the provider.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the 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 used all of this information to plan our

inspection.

During the inspection-

We spoke with three people who used the service and one relative about their experience of the care provided. We spoke with six members of staff including the registered manager, deputy manager, shift leader, two care staff and the activity coordinator. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records and nine medicine administration records. We looked at three staff files in relation to recruitment and seven staff supervision records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. Information requested was not responded to in a timely manner and some information was not provided. We spoke with two relatives by telephone and informed the Local Authority and the fire service of our concerns about the service.



Our findings

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

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

At our last inspection the provider failed to have adequate systems in place for managing medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Using medicines safely

- Safe medicine practices were not promoted. People's medicines were not fully secure. On day one of the inspection we saw the medicine cupboard door had fallen off its hinges. Staff told us it had broken on Saturday which meant the medicines were insecure for three days. During the inspection it was repaired however, we observed the medicine trolley had no lock and was only secured by a chain and small padlock, in a room which had a standard household lock on it. This is not in line with pharmaceutical guidance on the safe storage of medicines in care homes.
- Records were not maintained of the quantity of medicines received into the service and the medicine administration records showed gaps in administration of medicines such as Ensure, Frusemide, eye drops, inhalers and topical creams. The gaps were not noted or acted on to establish if medicines were missed or if it was just missed signatures.
- Guidance was in place for some people's "as required" medicines such as paracetamol, however guidance was not provided for other "as required" medicines such as loperamide, cosmolon and codeine phosphate.
- The service had a number of people on topical cream applications. A topical medicine administration record was not in use to guide staff on where the topical creams were to be applied. Eye drops were not specific as to which eye the drops were to be put in.
- A system was in place for returning medicines, however we found a medicine dispensed in 2018 had an expiry date which had faded, and we were unable to establish if it was still in date. The medicine trolley and room were disorganised, which had the potential to increase risks around medicine administration.
- The service had six staff who were responsible for medicine administration. The registered manager

confirmed staff were trained and had their competencies assessed to administer medicine. However, the registered manager and deputy manager were only able to locate a record of competency assessment for one of the six staff which was completed in January 2019.

Systems were either not in place or robust enough to demonstrate people's medicines were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risk management was not effective and put people at risk. The service supported people who had the potential to present with behaviours that challenged. We saw incidents recorded in people's files which supported that. However, the risks associated with behaviours that challenged were not identified or mitigated to safeguard people. People's records showed inconsistency in the way incidents were managed which further increased risks to people and staff.
- Historic risks which had the potential to put the service at risk were not identified and managed. The registered manager was aware of a person's history but failed to identify and mitigate the risk. Some people admitted to the home smoked or used e-cigarettes. The potential risks of people smoking had not been identified or managed. We observed a person smoked in their bedroom and another person used a e-cigarettes in communal areas of the service.
- Guidance was provided on special diets. However, we observed these were not adhered to. This placed people at risk of reacting to the meal they had eaten.
- A person was being cared for in bed. A waterlow risk assessment (pressure risk assessment tool) was completed. However, there was no evidence to indicate the person was turned regularly to promote good skin integrity. During the inspection we saw they were positioned on their back. This had the potential to increase the risk of them developing pressure sores. During discussion with staff they had not considered that the person required regular repositioning. A moving and handling assessment was completed which outlined the number of staff and equipment required to move the person safely. The risk assessment made reference to using a sling, but no detail was provided on the type of sling to be used and that it required checking prior to use.
- Systems were not in place to promote a safe environment. Throughout the inspection we saw fire doors were propped open and under the stairs was used as a storage area. The emergency fire bag was stored in an office at the rear of the property and not readily accessible to staff. An external side gate was secured by a padlock, which had the potential to delay evacuation in the event of a fire. The fire records showed the fire system and equipment was serviced and weekly fire checks were carried out. However, the last fire drill was recorded as taking place in May 2019. The time of the fire drill was not recorded, and the frequency of fire drills was not determined or known by staff.
- People had a Personal Emergency Evacuation Plan (PEEP) in place. However, the fire evacuation procedure indicated sufficient staff were not provided to enable them to evacuate people in line with the provider's procedure. An environmental risk assessment was in place; however, it showed some environmental risks had not been reviewed since 2018 and the environmental risk assessment did not evidence that the risks around the use of free-standing heaters had been considered. We referred our concerns around fire safety to the fire safety authority, who visited the service following our inspection and sent the provider a letter of actions to complete to meet fire safety regulations.

Risks to people were not appropriately managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Infection control risks were not identified and managed. The service had no infection control risk assessment in place and infection control audits were not taking place.
- The service had a part time cleaner and a cleaning schedule was in place, however we found areas of the home and soft furnishings were not suitably cleaned and hygienic. The toilets in people's bedrooms were dirty, the cooker and oven were dirty, carpets were stained and some people's beds, including the divan, duvets and pillows were unhygienic.
- We observed disposable gloves left on a table in a person's bedroom and staff did not know if they were used or not.

Infection control risks were not managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- There was no system in place to enable the registered manager to have an overview of accidents/incidents to enable them to pick up trends, learn lessons and prevent reoccurrence. Incidents between people were not recorded as an incident and therefore no preventative measures were identified or put in place.
- An incident investigated by the Local Authority showed actions were required. A team meeting had taken place to discuss the incident to promote learning, but the suggested actions were not recorded as taking place.

Accident and incidents were not managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Systems were not in place to safeguard people. Staff were trained in safeguarding but some aspects of practice, such as sleeping on shift and ignoring guidance had the potential to put people at risk.
- Staff understood that incidents between people would be perceived as a safeguarding incident. However, we saw in records viewed a number of incidents of physical abuse between people which was not reported to the Local Authority safeguarding team to be investigated. As a result, no safety measures were put in place to safeguard individuals. At the inspection we asked the registered manager to make the required safeguarding referrals. This was followed up by two emails to them, which were not responded to or acted on. As a result, we made safeguarding referrals in respect of the incidents we were aware of from the records viewed.

People were not safeguarded from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection we made a recommendation that the provider made further efforts to recruit a cook, to free-up time for care workers to support people, especially in the morning.

At this inspection not enough improvement had been made and the provider was now in breach of regulation 18.

- Safe staffing levels were not maintained. The service had an established staff team and the registered

manager told us they had no staff vacancies. The registered manager and staff told us two staff were provided on each day time shift, with a cook sometimes on the morning shift. Waking night staff and a sleep-in staff member were provided at night. The service had a part time cook, cleaner and activity coordinator.

- Staff told us the staffing levels were sufficient when they had the cook or a third staff member on duty to assist with the cooking. The rota over a period of three weeks showed 19 out of 21 shifts where a cook was not on shift and only two staff were provided.
- The hours staff worked were not monitored. One staff member regularly worked the sleep-in shift but also worked day time shifts. Over a period of three consecutive weeks they worked long days (14 hours) followed by a sleep in and a 14 hour shift the following day. On week one of the rota viewed they worked 62 hours day shifts and seven sleep in shifts. Week two they worked 70 hours day shifts and seven sleep in shifts and week three they worked 62 hours day shifts and seven sleep in shifts. The registered manager told us staff working long days had an hour's break however, this was not recorded. On two consecutive dates another staff member worked the late shift from 3pm and then went on to work the waking night shift. This was a total of 17 hours followed by another 17 hours the afternoon and night after. The registered manager told us staff had signed a document to opt out of the 48 hour per week working time directive, but they had not considered the risks to people of staff working excessive hours. During the inspection we saw a staff member who was sat in the lounge observing people appear to be asleep. The registered manager was informed but there was no evidence on day two of the inspection this had been addressed.
- The service had no system in use to enable them to determine the number of staff required to meet people's needs. People's needs had changed, and one person required two staff for personal care and moving and handling. The person was cared for in bed and therefore two staff were not available at night to assist with personal care as only one waking night staff member was provided from 10pm. Their daily records showed no personal care or turns were provided overnight.
- During the inspection there was occasions where there was no staff present in the sitting/dining room. This left people unsupervised in a service where we know there were incidents of service user on service user abuse.

Sufficient numbers of staff were not deployed to meet people's needs and to ensure staff were not working excessive hours. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not recruited any new staff since the previous inspection. Therefore, we reviewed recruitment records for three staff who had been in post for some time. Checks were carried out such as obtaining references and Disclosure and Barring Service checks (DBS), which is a criminal record checks. However, we found some gaps in employment history and issues raised in references had not been explored.

We recommended the provider seeks advice from a reputable source about best practice in relation to the recruitment of staff to ensure people are protected from unsuitable staff.



Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law and Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care.

- The service had no new admissions since the previous inspection. We reviewed the assessment document for the newest admission to the service which was two years previously. Whilst we could see an assessment had been completed, the risks and needs identified by the assessment were not identified and mitigated and the service was unable to meet the person's needs. There was a delay in the registered manager addressing this which the person felt impacted on them.
- The person told us they were very unhappy living in the service. The person felt disliked and told us they had nothing in common with the people living there. Staff were unable to support the person adequately which further impacted on the person and others living at the service.
- People's care plans indicated they had access to other health professionals such as the GP, dentist, chiropodist, district nurse and Abbott nurses. A record was in place to record appointments and the outcome. However, these were not completed and, in some files, viewed there was no entries for appointments with health professionals since 2018.
- A person had a recent hospital admission with subsequent follow up appointments and physiotherapy input. There was no record maintained of the appointments and outcome. Therefore, the service could not be assured that the person got the support they required.

Person centred care was not provided. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A relative told us they were happy with the care provided. They commented "I feel happy, staff haven't changed in years and they know what [person's name] needs, and they seem to get that care". They told us they were kept informed of changes in their family member as and when changes occurred.

Staff support: induction, training, skills and experience

- People were not supported by staff who had received adequate training and support to promote their safety and well-being. The service had no new staff since the previous inspection. The newest staff member had an induction checklist in place, but this was not in line with the Care Certificate training. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme.
- Staff told us they had access to regular training. The training matrix viewed showed staff were trained in topics such as moving and handling, safeguarding, infection control, fire safety and dementia care. However, their practices and understanding of topics they had been trained in demonstrated that the training was not always effective in giving staff the skills to do their job. This resulted in infection control risks not managed, poor medicine practices and people on people abuse not acted on.
- Staff were supporting people with behaviours that challenged. They confirmed they had been trained in how to manage behaviours that challenged. However, staff told us they were frightened of individuals and did not know how to adequately manage the challenging behaviour situations they were presented with.
- The providers supervision policy outlined that one to one supervision would take place every other month and all staff would have an annual appraisal. Staff told us they had supervision occasionally. Some staff felt they were supported well by the deputy manager. Other staff described the support as "variable".
- The supervision records viewed showed some staff had two recorded supervisions each year, whilst other staff had only one recorded supervision each year. Two of the seven staff files viewed had a record of annual appraisal. The other five staff had no evidence of appraisals even though staff have worked at the home for many years. This was not line with the provider's policy on supervision.

Staff training was ineffective, and they were not suitably supported. This was breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection we recommended the home obtains its' own equipment for maintaining floors in a clean and hygienic condition. At this inspection not enough improvement had been made and the service is now in breach of Regulation 15.

- The service was not fit for purpose. The design and layout of the building meant people had to walk through the kitchen to get to the sitting/ dining area. The corridor from the kitchen to the sitting/ dining room was dark, uneven and the walls by the laundry room appeared to be damp with the paint flaking off. The kitchen cupboards were falling off their hinges and the worktop was damaged and no longer sealed and hygienic. Furniture in people's bedrooms had handles missing and/or drawers wouldn't close. At the rear of the property there was a hole in the pathway and the pathway by the fire exit was covered in debris and a slip hazard.
- A refurbishment, redecoration and replacement plan of furnishings and equipment was not in place. The registered manager told us the service was updated and redecorated as required. However, we saw this was not the case. During the inspection in response to our feedback the registered manager purchased a duvet, pillows and some bedroom furniture. However, this was not sufficient to address the general state of disrepair of the service and furniture.

The premises, furniture and fittings were not adequately maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A relative acknowledged the service "Looked tired" but they did not feel that impacted on the care their

family member received.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The training matrix showed all staff were trained in the MCA. Staff spoken with had variable levels of understanding of the MCA and people's records showed staff were not applying the training to their practice.
- People's care plans identified if they had capacity or not. Where it was deemed people did not have capacity a mental capacity assessment was completed in relation to 24-hour care and protection. However, decision specific assessments were not always completed.
- The service had some people who required to have their medicine administered covertly. The decision to administer the medicine covertly was agreed by the prescribing GP and a DoLS authorisation had been applied for. However, a mental capacity assessment and best interest decision was not completed to indicate why medicines were to be administered in this way. Another person moved bedrooms due to a change in their mobility. The person was deemed not to have capacity but there was no assessment in place for this decision even though this decision was made in their best interests. Some people were invited for screening checks such as bowel screening. We were told a person had not gone as it was not in their best interest. There was no mental capacity assessment or best interest decision record to support the decision.
- The service had people for whom DoLS was applied for. In records viewed we saw staff had recorded that a person was removed from a challenging behaviour situation. There was no indication to say how they were removed to establish if it was done in the least restrictive way.
- A record was maintained of the DoLS applications made. However, the records showed that some DoLS had expired before an application to renew it had been made.

Consent to care was not carried out in line with the principles of the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's care plans outlined their nutritional needs and risks. However, these did not always clearly state how nutritional risks were to be managed. For example, the water given with a Percutaneous Endoscopic Gastrostomy (PEG) feed and sips of other drinks taken was not recorded, so there was no record to show this was provided and nutrition maintained.

- A person's care plan indicated they needed to be reminded to eat. Their care plan did not outline how staff encouraged the person to eat to promote their well-being.
- We observed a person cared for in bed being supported with their meal. Their bed had not been adjusted to ensure the person was sat upright. This was pointed out to the deputy manager who addressed it with the staff member supporting the person.
- The service had a four-week menu plan in place. The home had a cook and in their absence care staff cooked the meals. A person described the meals as "okay". Another person was very dissatisfied with their meal and did not eat it. They described the chicken as "dry". They were offered alternatives but choose to have a pudding instead. On day two of the inspection we observed the gammon given to some people looked overcooked. There was no effective system within the service to gain feedback on the meals provided to bring about improvement.

We recommend the provider seeks advice from a reputable source about best practice in relation to promoting good nutrition and hydration.



Our findings

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

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

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

- People's privacy, dignity, independence and involvement in the service. was not always promoted. People had their own bedrooms and they were personalised with family photos. However, some bedrooms were sparsely equipped, impersonal and did not reflect individuals' choices and interests. Some furniture was damaged and their bedrooms lacked care and attention.
- We observed most staff knocked on people's doors before they went into their bedrooms. However, where bedroom doors were open some staff walked in without informing the person. Throughout the inspection a person's bedroom door was left open. The bedroom was situated by the entrance to the home and all visitors to the home had view of the person. There was no evidence the person's privacy and dignity had been considered and addressed.
- There was no evidence to indicate people were involved in their care. One person liked to cook and staff told us this was encouraged, but the frequency of this occurring was not regular or planned.
- During the inspection we observed positive and negative engagements with people. At the mealtime we heard staff regularly tell people to "Sit down", without any reassurance or support to do that. Staff consistently used terms of endearment when engaging with people such as "darling", "my love" and "good girl". We found no evidence this was how they wished to be addressed.

People were not always treated respectfully and their privacy and dignity was not always promoted. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some staff were observed to have more positive engagement with people. They used good contact, appropriate touch and spoke calmly to individuals when engaging with them.
- A person commented "It is alright here, staff are pretty good". Another person commented "Yes, I like it here".

- Relatives described staff as "Cheerful, kind, caring and fantastic".

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

- Person centred care was not provided. Throughout the inspection we observed people were able to choose when to get up and had a choice of meals and drinks. However, people had indicated they would like more activities out of the home, but regular community activities were not scheduled and provided.
- People did not have a keyworker and there was no evidence people were consulted with or enabled to contribute to their care.

Person centred care was not provided. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.



Our findings

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

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

Meeting people's communication needs

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

At the previous inspection a recommendation was made for work to be undertaken to make sure the service ensures people have access to the information they need, in a way they can understand it, to comply with the Accessible Information Standard.

At this inspection we found improvements had not been made.

- People were not supported with their communication needs. We asked for the provider's policy on meeting the AIS standard. This was not forthcoming.
- People's care plans made reference to people's communication needs. However, the care plans for people with dementia or cognitive changes did not indicate how short-term memory loss and dementia affected their communication and how this should be managed.
- A person's care plan on communication stated that staff needed to read a person's body language, monitor closely, use active listening and communicate with facial and hand gestures. There was no indication as to how staff would know what the person's body language meant and what facial and hand gestures were to be used to support this person's communication.
- People were not provided with information in a format suitable to their needs for example on choosing activities or how to make a complaint. Pictorial menus were on the notice board however, these were not routinely used to promote choices and inform people what was on the menu. On day two of the inspection pictorial menu cards on display were not reflective of the meal on offer and provided.

The service was not meeting the Accessible Information Standard. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences and End of life care and support

- Person centred care was not provided. Care plans were in place and whilst some care plans outlined people's needs and the support required, care plans lacked the specific detail on how person-centred care was to be delivered. Care plans indicated that a person was to be supported with personal care regularly, however the frequency was not determined. A personal care record was in place, but this was not routinely completed to indicate the care given.
- Care plans made reference to medical conditions such as diabetes but did not outline hypoglycaemic and hyperglycaemic symptoms of the condition for staff to be able to respond in a timely manner.
- A person was requiring daily exercises to promote their mobility. Guidance was provided by a physiotherapist who had been involved in the person's care. However, the records were not updated to reflect the required exercises were encouraged. The last entry was dated the 23 October 2019.
- Care plans were reviewed but the review failed to address changes in people or a person's lack of engagement in their plan of care.
- Some people had "Do not attempt resuscitation" forms in place. Their care plans made reference to an appointed funeral director. However, care plans did not evidence that people's end of life wishes were routinely explored and identified. They did not outline the end of life care required to ensure people had a comfortable and dignified death.

Person centred care was not provided. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the previous inspection a recommendation was made for people to be asked about their religious needs and that links established within the community, to meet these.

At this inspection we asked for an update on the progress with this. The registered manager sent us evidence of monthly hymn singing and advised that people have said they did not wish to attend a church service every week. There was no evidence provided to show how people were supported and enabled to make that decision.

- The service had an activity staff member who worked one to two hours five days a week to facilitate in-house activities. These activities consisted of bingo, throwing a ball and dominoes. A pat a dog service visited weekly and monthly art and craft sessions were provided. A questionnaire was completed to establish what activities people liked. These showed people had requested more trips out.
- Staff told us people were supported to go out for lunches, walks to the park and shops. It was not clear of the frequency of community trips as there was no record maintained of the trips that had taken place, other than a record in individual's daily records which was not easily accessible.
- A person commented "I do not think much of the activities and rarely get to go out". In a survey carried out between February and May 2019 three relatives had said that "enough activities were only provided sometimes".

Person centred activities were not provided. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy in place. A copy of the policy was on display by the entrance to the service, but this was not very conspicuous for visitors coming into the service. The complaints policy did not include information on how a complainant should contact external agencies such as the Parliamentary and Health Service Ombudsman if the complaint was not resolved to their satisfaction. Instead complainants were informed to contact the Care Quality Commission (CQC) which is incorrect as CQC do not investigate individual complaints.
- A complaints log was in place which showed no complaints were logged.

It is recommended the complaints policy is developed in line with good practice guidance to ensure people and their relatives are provided with up to date information on how to make a complaint.

- Two out of five relative surveys completed between February and May 2019, stated that they did not know how to make a complaint. There was a letter on file which showed a copy of the complaint's procedure was sent to relatives.
- A person told us they would tell staff if they had any concerns. A relative felt able to go to the registered manager with issues. They commented "I talk to the manager quite a bit so feel happy to raise issues with him".



Our findings

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

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

At the previous inspection the quality auditing systems were not effective, and the provider was in breach of Regulation 17.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Auditing and good governance was not effective in ensuring good outcomes for people. The service had a quality monitoring policy in place dated July 2019. It outlined that the success of the quality management system relies on regular audits and reviews. It indicated there was a timetable to carry out and complete audits and that all areas of care and practice was audited regularly. We found this had not been implemented.
- The registered manager carried out audits of care plans and medicines management and complete spot checks of the service. The deputy manager audited falls and DoLS applications. The last medicines audit was completed in November 2019 and care plans were audited in September 2019. However, those audits had not identified the issues we found in relation to care plans, medicine management and the environment.
- No systems were in place to audit other aspects of care and delivery. Infection control, health and safety, rotas and records were not monitored. As a result, we found practices such as staff working excessive hours was not identified and addressed, fire safety was not suitably managed and infection control risks were not mitigated.
- Records were not suitably maintained. We found records were insecure, disorganised, inaccessible, contradictory, inaccurate and some records were incomplete. Records were inaccessible such as the maintenance book and fire folder. For other records there was a delay in finding them as records were

disorganised and not filed appropriately. We found duplication of folders for accidents, incidents and falls which meant there was no overview of accidents and incidents. A4 books were used to record handovers, but there was no system in place to archive used ones to ensure they were accessible if required as part of auditing or an investigation. We found used handover books in various places throughout the inspection and the registered manager had no idea how many had been completed as they were not numbered.

- A diary was used to record the staff rota, which was unclear and in parts illegible due to crossings out and poor handwriting.
- People's records were contradictory and incomplete. For example, a person's care plan contradicted the assessment. The assessment indicated the person needed support with personal care and that they were at risk of falls. The care plan stated no support was required with personal care and they were fully mobile and independent. Within their care plan it referred to someone else and pages did not include people's names, they were not numbered, and this had the potential for pages to get misplaced and lost.
- Personal care records, exercise recording sheets, staffing signing in and out sheets, medicine records, food, fridge and freezer temperature records all showed gaps in recording.
- Records were stored in the upstairs office and in a room downstairs. Both offices were untidy with records spread out across a table, on the floor, on top of a filing cabinet and in a filing cabinet. Throughout the inspection the door to the downstairs room was left open and insecure.

The service was not effectively monitored and records were not suitably maintained. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service was not been effectively managed, and the registered manager failed to ensure the service was working to regulations. They failed to respond to our request for information to be sent to us after the inspection and did not make the required referrals to safeguard people. They failed to address poor practice when informed of it during the inspection.
- Staff told us they were clear of their role. Staff commented "I feel unable to carry out my role, we make suggestions, but they are not taken on board". "Sometimes you try to hint and hope it's taken on board".
- We received mixed feedback on the management of the service. Some staff told us they thought it was well managed and they were complimentary of the deputy manager. A staff member commented "[Deputy managers name] has improved many things". Other staff told us they did not think the service was well managed. Staff commented "I think [registered manager's name] has improved, but always more room for improvement" and "No, I don't feel the home is well managed, issues are raised but they are not addressed".

The service was not effectively managed. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Continuous learning and improving care and Working in partnership with others

- Systems were not effective for engaging and involving people, relatives and staff in the service. A system was in place to gain feedback from relatives on the care and service provided. The last survey was carried out from February to May 2019. However, there was no indication that issues raised or suggestions for improvement were addressed.
- Staff meetings took place. Six had taken place over 2019. However, the minutes from the staff meetings were usually brief and noninformative, except for one set of minutes following an injury to a person, where

staff were reminded of procedures following an accident.

- Resident meetings did not take place and minimal opportunity was provided for people to have their say on the service.
- There was no evidence of learning and improving care. Prior to this inspection the service has had a requires improvement rating for four consecutive inspections. The provider/registered manager failed to recognise what they needed to do to bring about the required improvements and as a result the service is now in special measures.
- The service did not work in partnership with others to support them to provide good care. Community links were not established and developed to further promote better care and opportunities for people.

Systems were not effective to get feedback on the service, promote continuous learning and work in partnership with others. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. In records viewed we saw incidences of challenging behaviour between people. The registered manager had failed to inform us of those and despite these been brought to their attention at and after the inspection, they failed to make the required notifications.

The required notifications were not made. This was a breach of regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) regulations 2009.

- The registered person must keep under review and, where appropriate, revise the statement of purpose. The statement of purpose provided was reviewed in 2018. It indicated it provided care to people 65 and over. However, the service was providing care to a person under 65 and they were unable to effectively meet this person's needs.

The statement of purpose was not reflective of the service user group they cared for. This was a breach of Regulation 12 (Statement of purpose) of The Care Quality Commission (Registration) regulations 2009.

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

- During discussion with the registered manager they showed poor understanding of the duty of candour regulation and was not clear if they had a policy on it or not. A policy was provided after the inspection dated 7 February 2020. Whilst the policy made reference to meeting with the person and their family it did not indicate that this would be followed up with a written notification to the person and their family member as outlined under Regulation 20.
- We saw an incident had occurred which met the duty of candour regulation. The registered manager could not recall if a duty of candour letter had been sent. The deputy manager provided us with a copy of the letter which they had sent, which outlined the incident and offered an apology.

We recommend the provider seeks advice from a reputable source about best practice in relation to working to the Duty of Candour Regulation.