Inspire Residential Care Limited

Morvern Care Centre

Inspection report

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21 September 2020

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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
Morvern Care Centre is a residential care home providing personal and nursing care to 48 people aged 65 and over at the time of the inspection. The service can support up to 60 people.

The care home accommodates 60 people across three separate units. Each unit had its own separate facilities. Two of the units had been joined together at the time of this inspection and supported people living with dementia.

People's experience of using this service and what we found
Although people told us they felt safe living at Morvern Care Centre, the service was not safe. Risk was not always assessed and managed to protect people from exposure to harm. Safeguarding processes were not always followed to minimise the risk of abuse. We could not be fully assured people got their medicines as directed. Medicines were not always managed safely and in line with good practice. Staffing levels were not always appropriate to meet the needs of people who lived at the home.

The service was not well-led. We found widespread and systemic failings throughout the service. . Oversight from the management team was inconsistent. . Audits were not effective in driving forward improvements within the home. Policies and procedures were not consistently followed to maintain safety. Records were not always accurate, up to date and reflective of people's needs. . Staff told us morale was low.

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.
Care was not always effective. Processes to ensure people consented to care and treatment were not always followed. When people required support with eating and drinking, we could not be assured peoples dietary needs were consistently met. The environment within the home was poorly maintained and did not always meet people's needs. Staff did not always have the appropriate training and skills to keep people safe. Health needs were not always met in a timely manner. We have made a recommendation about this.

Although we observed some positive interactions and staff spoke fondly of people, we found staff were not always caring and responsive to people's needs. Dignity and respect were not always considered and promoted. We could not be fully assured autonomy was promoted and people were consulted with. We have made a recommendation about this.

We could not always be assured people received person-centred care. According to records, people were not always offered baths and showers in a timely manner in line with their preferred needs and care plans. People told us activities took place and said they looked forward to activities. However, there were no organised activities when the activities coordinator was on leave. Additionally, we noted large amounts of time when people on the dementia unit were not provided with stimulus and activity.

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 21 April 2020.) The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of risk, safeguarding and the condition of the living environment. A decision was made for us to inspect and examine those risks.

We undertook a focussed inspection to follow up on the specific concerns we had received about the service. We inspected and found there were significant concerns, so we widened the scope of the inspection to become a comprehensive inspection which included all key questions.

We have found evidence that the provider needs to make improvements. Please see the full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing, consent, safeguarding, person-centred care, dignity and respect and good governance.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

Morvern Care Centre

Detailed findings

Background to this inspection

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

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

Inspection team
On the first day of inspection, one inspection manager and an inspector visited the home. On day two, the inspection manager returned to the home alone. On day three, two inspectors, and a pharmacist specialist advisor visited the home.

Service and service type
Morvern Care Centre 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.

Notice of inspection
We gave the service one days' notice of the inspection. This was because we wanted to be sure there was someone at the home who could assist us with the inspection process.

What we did before the inspection
We looked at what information we had received about the service since it was registered with the Care Quality Commission in April 2015. This included looking at information held on our database about the

service for example, statutory notifications completed by the registered provider and safeguarding concerns reported to the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with the local authority safeguarding team and also sought feedback from Lancashire and Blackpool contracts and commissioning teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with six people who lived at the home about their experience of the care provided. We spoke with the nominated individual, the registered manager, the deputy manager, the maintenance person, the cook, a member of the domestic team and eight members of staff responsible for providing care. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We carried out a visual inspection of the home to review the environment and to check the equipment used within the home. We did this to check the living environment was safe and suitably maintained. In addition, we observed staff interactions with people.

We reviewed a range of records. This included twelve people's care records and multiple medication administration records. We looked at three staff records to ensure suitable checks were in place. In addition, we reviewed multiple records related to the management of the service, including minutes of meetings and policies and procedures.

After the inspection
Following the inspection, we continued to speak with the registered provider to corroborate our findings. We looked at audits, staffing dependency assessments, staff training records and other documents gathered at the inspection visit.

We spoke with a health professional who had some oversight of the home and spoke with two relatives.

We liaised with the local authority safeguarding team, the environmental health team, Lancashire Fire and Rescue and the local authority contracts and commissioning teams to share our finding and raise concerns identified during the inspection process.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Risk was not always suitably addressed. People were sometimes exposed to risk of harm. Equipment used within the home to promote safety and well-being was not always suitably maintained. We identified significant concerns in relation to the nurse call bell system and sensor mats. We could not be assured these were fully operational and effective. One staff member said, "People are safe, apart from when the buzzers aren't working."
- Health and safety guidance aimed at keeping people safe was not consistently followed. We found risk was not being appropriately managed to ensure bed rails and sensor mats were used safely. Also, risks to prevent people from falling from height had not been consistently addressed and managed.
- The registered manager had failed to identify, and address risks associated with choking, unplanned weight loss and falls. When people were at risk of choking, risk had not been considered, reviewed and recorded.
- When people had displayed behaviours which sometimes challenged the service, reporting processes had not always been followed. Care plans and risk assessments had not been updated to reflect any risks presented and how to lessen risk.
- Systems and processes were not consistently implemented to promote skin integrity. We found staff hadn't followed the correct processes and had failed to identify a concern with one person's pressure mattress which had been provided to maintain the person's skin integrity.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we raised concerns with the nominated individual so action could be taken. We were not assured all risks had been reviewed and addressed. We raised safeguarding alerts to the local authority when people were deemed at risk of harm and liaised with the environmental health department for advice and guidance regarding the environment.

Using medicines safely

- Medicines were not consistently managed safely. We found multiple examples of poor practice which placed people at risk of harm.
- Processes for re-ordering of medicine were not robust. We found stock was not always available to ensure people received their medicines. Records maintained showed people had not received medicines as directed due to them being out of stock.
- Medicines, creams and ointments were not always stored securely. We saw these were left in rooms

unsupervised.
● Controlled drugs were not stored and recorded in line with controlled drug legislation. We could not be assured people had received their controlled drugs as staff had written over controlled drug records.
● People did not always get their medicines as directed. For example, one person's medicine was to be given 30 minutes before food. This was not followed. When people had medicines in the form of a transdermal patch, directions were not always followed to ensure the patch was suitably located.
● We could not be assured people were given the correct doses of medicines. We found stock counts of medicines did not always match information on the MAR record. Two people had been given too much medicine, but this had not been picked up by staff at the home. . We highlighted this to the registered manager and asked them to seek further guidance from health professionals.

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
● We were not assured infection control processes were being consistently implemented and followed. Staff were not always wearing the personal protective equipment in line with good practice. One staff told us they had not received any training around working safely in a COVID-19 pandemic. Another staff member told us they had a significant medical condition, but this had not been risk assessed.
● Equipment in the home was not suitably maintained to ensure it could be effectively cleaned. We found one bed rail which had significantly corroded. This could impact upon cleaning processes. Also, we identified not all mattresses were clean and free from stains.
● We identified some malodours throughout the home. We found one area of flooring was water damaged and could not be cleaned correctly. The registered manager told us they had requested new flooring from the registered provider, but this had not been actioned.
● Following the inspection visit on 11 September 2020, we asked the registered provider to carry out a full audit of the home and confirm how many mattresses were damaged or stained. They confirmed there were nine stained mattresses and one torn mattress that needed attention.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit we highlighted these concerns to the registered provider so they could act. Additionally, we escalated concerns to the infection, prevention and control team and liaised with the local authority to ensure concerns were shared.

Staffing and recruitment
At the last inspection visit, we recommended the registered provider reviewed their system for calculating staffing levels to ensure people's needs were met. At this inspection visit, we found improvements had not been made to ensure people's needs were consistently met.

● Staff were not always deployed effectively to meet the needs of people who lived at the home. The registered manager told us they had reviewed and amended the staffing calculator following feedback from the last inspection. However, we saw the staffing dependency tool was still not accurate and noted individual need was not consistently addressed. For example, one person was identified as having behaviours which challenged, but no support had been allocated to manage any behaviours which may have challenged.
● Two staff told us there were occasions when they never had enough time to complete tasks. One staff

member said, "We don't have time." Another staff member said, "There is too much to do." And, "We can't always answer bells in the morning."
● Oversight of people was inconsistent, and people were sometimes left unsupervised in communal areas. One person told us, "It's quite stressful for the staff, we could do with a few more, (staff.)"
● All staff responsible for planning and providing direct care said staffing levels were consistently low and said they felt pressurised into working additional shifts. Staff told us there was a high rate of staff sickness and said a number of staff had recently left. One staff member said, "Morale is low. We are short staffed. I have been doing five, twelve-hour days for plenty of weeks, covering for sick." We reviewed four weeks rotas and noted four staff members had worked over 60-hour weeks in a four-week period.

This was a breach of regulation 18 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, we spoke with the registered manager who provided us with assurances they were actively recruiting to fill the staffing voids.

Systems and processes to safeguard people from the risk of abuse
● The registered provider had a system for responding and reporting abuse. However, we could not be assured systems and processes were consistently applied.
● Staff told us they had received safeguarding training and were aware of the importance of reporting abuse and harassment. However, during the inspection visit we were made aware several incidents had occurred which exposed people to the risk of harm. The registered manager told us they were unaware of these as staff had not reported them in accordance with the policy.
● In addition, we identified an incident which had been reported to the management team and investigated by the registered provider but had not been reported to the local authority safeguarding team. This breached the organisations own policy on reporting and responding to safeguarding concerns.

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

Following the inspection visit we highlighted these concerns to the registered provider so they could act. We also liaised with the local authority safeguarding team so they could review all significant incidents to ensure people were safe from harm.

Learning lessons when things go wrong
● During the inspection visit, we asked to see completed accident and incident reports for people who lived at the home. Whilst reviewing the audit, we saw a significant number of incidents had been omitted from the audit. The registered manager had failed to notice this. We could not therefore be assured lessons were learned from accidents and incidents which arose within the home.

Inadequate

Is the service effective?

Our findings

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

At the last inspection 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.

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

- The service was not always adapted and decorated to meet people's needs. We asked people who lived at the home, relatives and staff their views on the home and feedback included, "The building is falling to bits." And, "It needs a bit of updating."
- On the first day of our visit, we carried out a visual inspection of the home. We identified some significant concerns related to the maintenance within the home. Concerns included patches of damp, wallpaper peeling off walls, water leaking into the building, a faulty window and two bathrooms being out of use.
- Following the visits on 11 and 14 September 2020, we wrote to the registered provider and asked them to carry out a full audit of the home. They confirmed within their audit, 14 bedrooms were exposed to damp, 20 bedrooms needed decorating, 24 rooms needed carpet replacing, and flooring in communal areas needed replacing.
- We spoke with the maintenance person, they expressed concern about the systems to enable them to carry out the work effectively. We saw evidence of the maintenance person chasing up maintenance requests with the registered provider.
- We spoke with the registered manager about the maintenance of the building. They told us this was the responsibility of the registered provider. They expressed concern there was too much work for the maintenance person to keep on top of and told us they had reported these concerns to the registered provider.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, we spoke with the registered provider and expressed concerns about the poor living standards within the home. They told us maintenance in the home was ongoing, but this had been delayed due to the COVID-19 pandemic. They provided us with an action plan to show improvements were planned. Following our inspection visit, we saw works had restarted in the home.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

● Processes for achieving consent were unclear and inconsistent. On the first day of our visit, we reviewed five care records and identified concerns in relation to consent to use bed rails and sensor mats.
● After the visit, we wrote to the registered provider and asked them to respond to specific areas of concern where consent should have been sought. The provider responded and confirmed consent for bedrails had not been agreed for twelve of 14 people. Additionally, no consent had been agreed for 27 people who required a sensor mat in place for monitoring.
● The registered provider had CCTV cameras in communal areas of the home which were operating at the time of the inspection. The registered provider confirmed people had not been asked to consent to being monitored and filmed by CCTV cameras.
● We saw systems had not been consistently followed to seek permission for people who lacked capacity to have invasive procedures carried out, prior to procedures taking place. We asked the registered manager to confirm this was correct. They could not provide us with assurances that consent had been sought from the relevant person beforehand or best interests discussions had taken place and recorded.
● The registered manager understood the principles of the MCA, but the principles were not consistently applied. When people lacked capacity, some but not all mental capacity assessments had been undertaken and best interest decisions had not consistently taken place to ensure decisions were made in the best interests of people.

This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, we received reassurance from the registered provider that improvements were being made to ensure consent was consistently sought, in line with the principles of the MCA and in a timely manner.

Staff support: induction, training, skills and experience
● Staff working at the home were supported to access training to enable them to have the skills required to meet people's needs. The registered manager maintained a training matrix to record all staff training. We saw staff were supported to complete training in areas including safeguarding of vulnerable adults, infection control and moving and handling.
● Although training was provided, we identified some areas in which we could not be assured staff had not received appropriate training. We identified one person who had a specific medical condition, we asked the registered manager if staff had training to manage this condition. They confirmed they had not had any training.
● During the inspection we were made aware one person required their food preparing in a specific way. We spoke with the cook to ensure they had the relevant skills. They confirmed they had not had any relevant training and were not aware of current guidance. We spoke with the registered manager about this training. They confirmed staff had not had any training to support them with managing specific diets and choking.
● During the inspection process, we were made aware of a situation in which one staff member had made some errors within their practice. We looked at the staff members personal records and saw that no

additional training had been offered and their competency skills had not been reviewed. We asked the member of staff to clarify if any further training and support had been provided. They confirmed it hadn't. They said, "I had no extra training. There was no support there for me."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff had all the appropriate skills to meet the needs of people who lived at the home. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act (Safe care and treatment) 2008 (2014).

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

- We could not be assured people's needs, and choices were always assessed and considered so care could be delivered in line with standards, guidance and the law. Good practice guidance was sometimes referred to within care plans, but we were not fully assured it was consistently followed. For example, screening tools for managing weight loss had been used but incorrectly completed and action had not been taken.
- Care plans were reviewed monthly, but we could not be assured the reviews were accurate and reflective of people's changing needs. For example, one person's records had not been updated after several significant repeated incidents.
- Although we received positive feedback from people about the quality and availability of meals provided, we were not fully assured people received the correct support to meet their dietary needs. When people required support with eating and drinking, support was not always provided as directed within the care plan. For example, one person required prompting and encouragement to eat but this support wasn't consistently provided. Another person required their meal prepared in a specific way, but we were not fully assured this consistently happened.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. his was a breach of Regulation 9 of the Health and Social Care Act (Person Centred Care) 2008 (2014).

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Systems were in place to ensure people had access to health care, however, we were not fully assured these systems were effective. During the inspection, we noted staff had not followed the GP's advice and referred a person to another health professional in a timely manner. This had not been identified as a concern by the staff team or the registered manager and had not been acted upon.
- As a result of COVID-19, the registered provider had worked in partnership with other health professionals to establish a weekly virtual ward round. Technology was used to communicate between staff at the home, people and health professionals. We spoke with a health professional, they were not confident however, that staff had embedded and embraced the new system. They said, staff were not always prepared and using the system effectively.
- We spoke with a member of staff they told us they had not had any additional training or support to provide them with the skills to carry out a virtual ward round.

We recommend the registered provider reviews systems and processes to ensure systems for working with other agencies are effective and timely.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as 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; Ensuring people are well treated and supported; respecting equality and diversity

- Staff spoke fondly of people and told us they were committed to caring for people who lived at the home. However, our findings did not always demonstrate staff were caring. One person told us, "Nothing is too much trouble for staff, unless they are busy. They are overworked and under pressure."
- Dignity was not always promoted within the home and people were not always treated well.
- Staffing levels sometimes impacted on people's dignity as interactions between people and staff were limited and there was a focus on completing tasks. A member of staff told us, "We don't get to spend time with people. We don't have the staff." When people required support at meal times, staff did not dedicate time to people but moved between people supporting them all at the same time. Additionally, we observed a staff member administering medicines. The staff member did not always afford people time to promote dignity and respect.
- Living conditions within some areas of the home were of a poor standard. These poor living standards had not been addressed in a timely manner. This compromised people's human rights as the registered provider failed to respect and protect the person's right to live with dignity.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act (Dignity and respect) 2008 (2014)

- We observed staff promoting people's independence and privacy. Staff knocked on doors before entering. One person told us they were able to carry out tasks around the home to remain independent.

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

- People told us they were able to have some choice and control within their lives. One person told us they could choose when they went to bed and what they ate.
- The registered manager confirmed people were consulted with regularly through residents' meetings.
- Although we saw some evidence of people being consulted with and involved in making decisions about their care, this was not consistent. For example, one person's care record stated the person did not need a bed rail, but a bed rail had been used. There was no evidence within the persons care record of this being discussed and agreed with the person.

We recommend the registered provider reviews and implements good practice to ensure people are

consistently involved and communicated with.

Requires Improvement

Is the service responsive?

Our findings

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

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

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

- Although some people told us they were able to have some choice and control within their lives, we were not fully assured people always received consistent personalised care to meet their needs and preferences.
- Care records did not always include all key information required to safely support people. For example, when people had specific medical conditions, information was not always documented about how the medical condition presented and how to safely support the person.
- During the inspection, one staff member told us staffing constraints sometimes meant people could not be bathed.
- We spoke with a health professional who had some oversight on the home. They expressed some concerns about the standards of personal care maintained for people who required support with bathing.
- We looked at wellbeing and bathing records completed for people who required support with their personal care. . Records indicated some people were not always supported to have a bath regularly. One person's care record stated they would like a bath at least once a week. Records indicated the person did not have a bath for 22 days on one occasion and 62 days on another. Records maintained by staff, suggested another four people had not been offered baths in accordance with the care plan.
- We raised these concerns with the registered manager. They told us this was a documenting error and people had been supported to have baths. This however, conflicted with a set of team meeting minutes, where it had been highlighted to the staff team that people were not getting baths.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act (Good governance) 2008 (2014).

Following the inspection visit, we raised safeguarding alerts with the local authority and raised these concerns with the registered manager. The registered manager agreed to review records to provide us with assurances this was a recording error. However, no further information was supplied to give us confidence that people had received baths in a timely manner.

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;

- Activities were planned and organised by the activities coordinator. Feedback included, "We have activities every day, apart from the weekend. It's a bit quiet at weekends." And, "She [activities coordinator] is marvellous. I don't know what I would do without her".
- Although an activities coordinator was in place, we noted no arrangements were in place for planned

absence of the activities coordinator. On the first day of the inspection a member of staff, told us they felt dreadful as one person had been looking forward to the weekly bingo, but it wasn't going ahead due to the activities coordinator being on leave and no other staff having the time to organise it.

● Although people on the residential unit praised the activities provided, we noted on the unit for people living with dementia, people were left without any meaningful activity for long periods of time. We discussed good practice which supported activities for people living with dementia such as twiddle muffs and rummage boxes. The registered manager said they used to have items around the building but was unsure as to what had happened to them.

● Relatives we spoke with told us their loved ones were supported and encouraged to maintain links with them. They told us they had regular contact through phone calls with them.

End of life care and support

● Staff told us they had received end of life care training and understood the importance of providing high quality care for people at the end of their life. One staff member said, "I enjoy it. It's the last thing we can do for people. If they have no family, we are the familiar faces."

Meeting people's communication needs

Since 2016 onwards 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.

● Some provision had been made within the home to meet the standard. Signage around the home had been adapted to make it more accessible and communication was considered within sometimes considered in the care records we reviewed.

Improving care quality in response to complaints or concerns

● The registered provider had a complaints policy and procedure for managing complaints. No one raised any complaints during the inspection process.

● We reviewed the complaints log and saw a record of all complaints was maintained by the registered provider.

Inadequate

Is the service well-led?

Our findings

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

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

At the last inspection visit, the provider had failed to ensure processes were implemented and improvements had been made to ensure compliance with the Regulations. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered provider did not fully understand their responsibilities and regulatory requirements. The service has been inspected three times since 2019 and has failed to meet the required standards at each inspection. Improvements made at the last inspection had not been made, embedded and sustained. Concerns we identified during the inspection had not been identified by the registered manager or the registered provider.
- Continuous learning and a focus on improving care was inconsistent. We could not be fully assured lessons were being learned in order to improve care.
- Organisational policies and procedures were not up to date with regulations and law and were not consistently followed to keep people safe and deliver high quality care.
- Concerns identified at the last inspection regarding the effectiveness of the auditing system remained. We were not provided with assurances improvements had been made and auditing systems within the service were implemented and effective. Audits which had taken place had failed to identify the concerns we found, including significant concerns within safeguarding processes, accident and incident monitoring, the environment, consent, person-centred care, management of medicines and management of risk. When audits had identified concerns, no action had been taken to make improvements.
- Accidents and incident reviewing systems and safeguarding processes were not robust. We could not therefore be assured the duty of candour was consistently applied and the registered provider was open and honest when things had gone wrong.
- Concerns identified at the last inspection remained. Improvements had not been made to records. Documentation was not always complete, accurate and up to date. Care records were missing key points of information which were important to promote safe and effective care. Screening tools and weight management records to support people's care were not always accurate. Medicines administration records were missing signatures, not correctly completed and missing key information. We identified errors in every

care record we viewed. We could not be assured therefore that people weren't exposed to the risk of harm.
● Records were not always stored securely to promote confidentiality. On the first two days of inspection, we noted personal records were left unsecured in communal areas. On one occasion, one person had access to personal care records. We could not be assured they were their own personal notes.

We found no evidence that people had been harmed however, systems were either not in place, followed or robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others;

● The culture within the service was not consistently person centred and did not always achieve good outcomes for people. Systems and processes did not promote person centred care. For example, staffing calculations and management of unplanned absence, infringed on people's choices and rights.
● Concerns identified at the last inspection in relation to person centred records remained. Language used by staff was not always person-centred, for example, staff referred to a "toileting programme" for one person and stated a person "suffered with dementia." Additionally, important person-centred information which would promote effective and safe person-centred care was not always present in records.
● Action had not always been taken to improve people's lives. Processes for ensuring the upkeep of the building were not robust to ensure peoples wellbeing was always considered. Partnership working with other health and social care professionals was inconsistent and not always pro-active. We could not be assured professional advice was consistently sought and good practice implemented.
● We could not be assured the registered manager consistently understood and applied the principles of the Mental Capacity Act 2005, (MCA.) The MCA aims to empower people to make decisions. When people lack capacity to make their own decisions, the act ensures decisions made by other people are lawful and in their best interests. This act had not been consistently followed by the registered provider.

We found no evidence that people had been harmed however, systems were either not in place, followed or robust enough to demonstrate the service was effectively managed. This was a 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;
● The registered manager told us the activities coordinator held residents meetings with people to discuss how the home was run. However, we found processes were not fully embedded and implemented to provide us with assurances that people who lived at the home were fully consulted with.
● We saw evidence of team meetings taking place on a regular basis. We were not provided with assurances however, that these meetings were fully effective. Staff told us communication and support from senior management was inconsistent. Feedback included, "I don't know if we are listened to. Sometimes it feels like we aren't." And, "We have meetings and can suggest things. We aren't judged."
● Relatives we spoke with told us that due to COVID-19 restrictions there had been restrictions on their visiting. However, they said they continued to be consulted with when appropriate.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure care and treatment of service users was appropriate, met their needs and reflected their preferences. 9 (1) (a) (b) (c)

The enforcement action we took:

CQC issued a Notice of decision and cancelled the registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure dignity and respect was consistently provided. 10 (1)

The enforcement action we took:

CQC issued a Notice of decision and cancelled the registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to ensure dignity and respect was consistently provided. 10 (1)

The enforcement action we took:

CQC issued a Notice of decision and cancelled the registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure care and treatment must be provided in a safe way for service users.

	The registered manager had failed to assess the risks to the health and safety of service users of receiving the care or treatment; The registered provider had failed to do all that was reasonably practicable to mitigate any such risks. The registered provider had failed to ensure the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. The registered provider had failed to ensure the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; The registered provider had failed to ensure that there were sufficient quantities of medicines. The registered provider had failed to ensure the proper and safe management of medicines; The registered provider had failed to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated 12 (1) (2) (a) (b) (c) (d) (e) (g) (h) (I)

The enforcement action we took:

CQC issued a Notice of decision and cancelled the registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to ensure systems and processes were established and operated effectively to prevent abuse of service users. 13 (1) (2) (3)

The enforcement action we took:

CQC issued a Notice of decision and cancelled the registered providers registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure all premises and equipment used within the service was clean, secure, suitable for the purpose for which they are being used, properly used and properly maintained, 15 (1) (a) (b) (c) (d) (e)

The enforcement action we took:

CQC issued a Notice of decision and cancelled the registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure systems and processes were consistently implemented to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users 17 (1) (2) (b) The registered provider has failed to ensure records were accurate. 17 (1) (2) (c) The registered

The enforcement action we took:

CQC issued a Notice of decision and cancelled the registered providers registration.