TLC Care Management Ltd

Calderdale Retreat

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Calderdale Retreat is a purpose built residential care home providing personal and nursing care for 41 people aged 65 and over at the time of the inspection. The service can accommodate up to 81 people across three separate units, each of which has adapted facilities. Only two units were operational; one unit provided nursing care, the other provided care for people living with dementia. The other unit was closed.

People's experience of using this service and what we found
People were not safe. Risks were not assessed and appropriately managed. When accidents and incidents had occurred, action was not always taken to keep people safe. Lessons were not learned when things went wrong. Medicines were not managed safely. There were not always enough staff to give people the care and support they needed, particularly on the unit for people living with dementia. The recruitment process was not always followed robustly. Complaints were not always dealt with appropriately.

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. Staff received induction and training, however this did not always equip them with the skills needed to do their job. Some staff had received supervision, but others had not. People did not always receive the healthcare support they needed in a timely way.

People received a choice of food and drinks. The environment was clean, well maintained and furnished to a good standard. People and relatives said they liked the staff, although we found staff practices varied. Some staff were kind and caring, whereas others weren't, and people's privacy and dignity were not always maintained.

People's care records did not fully reflect their needs. Activities were provided by the activity organiser who was praised by people and relatives.

The service was not well-led. Leadership was weak and inconsistent due to repeated management changes in 2019 which, combined with a high turnover of staff, had impacted negatively on the service. Staff, people and relatives told us communication about these changes was poor. The provider's quality assurance systems were not effective in identifying and addressing issues. The service has a history of providing poor quality care; it has only been awarded ratings of requires improvement or inadequate.

Following this inspection we met with the provider to discuss our concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was requires improvement (published 5 June 2018).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to safe care and treatment, person-centred care, dignity and respect, staffing, recruitment, complaints and good governance at this inspection.

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 referred our concerns to the local safeguarding authority and asked the provider to send us evidence of improvements and action points. This was used when decisions were made about our regulatory response.

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 responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Calderdale Retreat

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
On 22 May 2019 the inspection team consisted of four inspectors and an Expert by Experience.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 23 May 2019 an inspector and medicines inspector attended and on 3 June 2019 three inspectors carried out the inspection.

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

The service had not had a manager registered with the Care Quality Commission since February 2019. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first and third day. The provider knew we were attending on the second day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and clinical commissioning group. 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 five people who used the service and seven relatives about their experience of the care provided. We spoke with sixteen members of staff including the company directors, the nominated individual, the manager, supporting manager, nurses, senior care workers, care workers and the activity organiser. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

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

- Risks to people were not assessed or managed appropriately placing them at risk of harm or injury.
- Pressure relieving mattresses were not set according to the person's weight placing people at risk of skin damage. One person who had a pressure ulcer was lying on a pressure relieving mattress set to 200kgs when their weight was only 50.5kgs. The nurse in charge did not know how to adjust the setting. Two other people's mattresses were set incorrectly.
- We observed staff using unsafe moving and handling practices when assisting two people to transfer from chairs. Both people were unable to support their own weight; staff did not use any aids and were struggling to keep people upright. Care records for both people gave conflicting information about their mobility and the support they required from staff.
- Accidents and incidents were recorded but not followed up to make sure actions had been taken to keep people safe. One person had a fall in February 2019 and it was identified they needed to be assessed for a specialist chair. Discussions with staff and review of the person's care records showed no action had been taken to address this matter.
- One person had fallen in April 2019 and it had been identified sensor equipment was needed to prevent further falls. This was not in place.
- Fire safety systems were not robust. Staff had received fire training and been shown how to use evacuation aids; however, no fire drills had been carried out since the last inspection in May 2018. This was concerning as there had been a high turnover of staff since then.

People were placed at risk of harm due to poor risk management. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure risks to people were assessed and managed. They confirmed fire drills had been held with staff.

- The premises were well maintained. Checks of the building and equipment safety were completed and recorded.

Using medicines safely

- Some aspects of medicine management were not safe. Most medicines were stored securely, although thickeners (used to thicken fluids for people with swallowing difficulties) were not and there were no records to show when they had been used.

● Documentation was not available to support staff to give people their medicines according to their preferences.
● Temperature records to ensure the safe storage of medicines were not always completed daily in accordance with national guidance.
● There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for abuse). However, staff did not carry out regular balance checks of controlled drugs in accordance with the home's policy.
● On the second day of the inspection staff advised only one person received their medicines covertly (hidden in food or drink) and we saw appropriate records were in place. However, on the third day of the inspection we found another person had been receiving their medicines covertly and the correct procedures for this had not been followed.
● Managers and members of staff qualified to handle medicines had completed frequent audits to make sure procedures were followed. However, the shortfalls we found had not been identified.

Medicine management systems were not always safe which place people were placed at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure medicines were managed safely.

● When people were prescribed medicines via a patch, there was a system in place to record the site and time of application.
● We observed some people being given their medicines and saw staff gave these in a compassionate way and were competent for this role. People were given their medicines at the right time.

Staffing and recruitment
● Staffing arrangements were not effective in meeting people's needs or keeping them safe. On the unit for people living with dementia we observed people repeatedly calling for assistance and waiting for up to 25 minutes for staff to attend to them. On occasions we had to look for and ask staff to assist people due to safety concerns or to meet the person's needs.
● One person required one-to-one support throughout the day yet there were no systems in place to make sure this happened. On several occasions we saw the person did not have one-to-one support from staff for periods of up to an hour.
● There had been a high turnover of staff since the last inspection and recruitment was ongoing. The service was reliant on agency staff and staff brought in from another of the provider's services which had not yet opened. Duty rotas were not accurate as they did not include all the staff working in the home.
● Feedback about the staffing arrangements from people, relatives and staff varied. Most felt there were enough staff on the nursing unit, but not on the unit for people living with dementia.

The lack of sufficient, competent staff meant people were not safe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure staffing arrangements met people's needs.

● Recruitment processes were not robust as appropriate checks were not always completed before staff began working in the service.

● There were no references for one member of staff who had commenced employment in December 2018. Another member of staff had no reference from their last employer. There were no interview records for either staff member.

The lack of robust recruitment checks placed people at risk of harm. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure robust recruitment processes were followed.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of abuse as actions had not been taken to keep people safe.

● Staff followed safeguarding procedures and reported incidents which were recorded and referred appropriately to the local authority safeguarding team. However, incidents were not always fully investigated or followed up to make sure people were protected from further abuse.

● One person required one-to-one staffing throughout their waking hours to keep them and other people safe. We observed one-to-one support was not always in place. Incident reports showed the person had hurt other people and themselves when they were supposed to be receiving one-to-one support. Despite this no action had been taken to review the risks to ensure people were protected.

Learning lessons when things go wrong

● Accident and incident reports were analysed monthly by the manager; however these processes were not effective as lessons were not learned when things went wrong.

● Issues the inspectors identified and reported to the manager and provider on the first two days of the visit had not been actioned when we returned on the third day. This included the provision of sensor equipment for one person, one-to-one support for another person and the safe storage of thickeners.

The lack of learning meant people were at risk of avoidable harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure people were protected and lessons were learnt when things went wrong.

Preventing and controlling infection

● The home was clean and effective systems were in place to prevent and control infection.

● Staff had received infection control training. They followed infection control procedures, washing their hands and wearing personal protective equipment such as gloves and aprons appropriately.

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 requires improvement. 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.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People were not supported appropriately to have choice and control of their lives because the key principles of the MCA were not always applied.
- Mental capacity assessments did not always reflect people's needs and were not decision specific. One person's care plan stated they had capacity to make their own decisions and they had no impairment or disturbance in the functioning of the mind or brain as determined by stage 1 of the MCA assessment. Yet the person was living with dementia and staff confirmed the person was confused and struggled to make some decisions.
- Mental capacity assessments and best interest decisions were not always completed. None had been completed for one person who had constant staff supervision during the day and sensor equipment in place.
- Two people's care records showed they had appointed someone to make decisions on their behalf through a lasting power of attorney (LPA). There are two types of LPA; one for health and welfare and the other for property and financial affairs. There were no legal documents for either person to confirm the type of LPA that was in place.
- Staff were not aware of who had DoLS authorisations in place. We asked three care staff, including a senior, and none knew.

There was a lack of effective systems to ensure people's consent was obtained and the principles of the MCA were followed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A tracker was in place which showed when applications had been made, who had authorisations and the expiry date and whether there were any conditions on the DoLS. We checked conditions on one person's DoLS and these were being met.

Staff support: induction, training, skills and experience
● Staff received induction and training however this did not always provide them with the skills and competencies they needed to do the job.
● Staff were not skilled in speaking with or supporting people living with dementia. For example, when transferring people, staff used long complex sentences, gave several instructions at once and lacked patience.
● Staff were not always competent in moving and handling techniques, which we witnessed on two occasions when staff struggled to transfer people safely.
● Staff lacked the knowledge and skills to appropriately support people who displayed behaviour that challenged. We saw one person was removing their clothes in the lounge and the care staff who attended did not have the skills to manage this discreetly and effectively. Training records showed only 16 of the 22 care staff employed had received training in managing challenging behaviour.
● The training matrix showed the majority of staff were up to date with training the provider deemed mandatory. Although one staff member had not received any training in key areas such as fire safety, health and safety, dementia and record keeping.
● There were not effective systems in place to make sure staff received regular supervision. Two staff told us they had not received any supervision since they started employment; one of these staff had started in November 2018. The acting manager acknowledged there was a backlog which they were planning to address.

The lack of effective training and support meant staff were not enabled to carry out their role competently. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure staff had the required knowledge and skills for their roles.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they moved in to make sure the service was suitable for them.
● People's care and support needs were assessed and recorded electronically. However, records we reviewed did not always accurately reflect people's current needs and preferences.

Supporting people to eat and drink enough to maintain a balanced diet
● People gave mixed feedback about the food. Comments included: "It depends on what they give you", "It is not brilliant", "I don't like the way they cook it" and "It is quite good."
● At breakfast and lunch people were offered a choice of food to meet their needs and preferences. One person required a specialist diet to meet their religious and cultural needs and this was provided. Menus were displayed with pictures of the food choices.
● People were offered regular snacks and drinks throughout the day. People who chose to stay in their rooms had drinks to hand.
● Information about people's specialist dietary needs was variable. For one person the information was detailed clearly showing their needs and preferences. However, for another person there was a lack of clarity about the food and drink they could have.

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

● People's health care needs were not always met as specialist advice was not always accessed in a timely way. An incident had occurred with one person in April 2019 and the manager had recorded the person had been referred to the mental health team. The manager told us the mental health team had not visited but said the GP had, yet they were not able to provide any records to evidence this. A GP visit was arranged once we raised this.

● When specialist advice had been given this was not always acted upon by staff. One person complained their eyes, which were red and sticky, hurt, yet no action had been taken by staff to address this. Medical advice was sought after we raised the issue and instructions were given to bathe the person's eyes four times a day with cooled boiled water. Records showed this was not completed.

● Staff were not always able to find information on the electronic care record system to confirm whether people had received healthcare support when they needed it. This was discussed with the provider at feedback.

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

● The home was purpose built and designed to meet people's individual needs. All areas were well maintained, decorated and furnished to a high standard with signage to help people find their way around.

● People's rooms were spacious and had ensuite facilities. People were encouraged to bring in their own belongings to personalise their rooms.

● There was a choice of communal areas on each floor. However, we observed people liked to congregate in one lounge on the ground floor and there were not enough chairs to accommodate everyone. This lounge had patio doors to a safe garden space, but the doors were kept locked and staff told us people could only access this space when staff were present. The provider said they would review this when we shared our observations.

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.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us staff treated them well. However, we observed variations in how people were treated by staff. Although we saw some caring interactions we also observed staff who were not compassionate and did not respond appropriately to people.
- We heard one person in their room calling out repeatedly. A care worker walked past their room saying, "You'll have to wait I can't do you by myself you need two people." Ten minutes later the person was still calling out. We asked the care worker who the person was, they replied, "[Name of person]'s always doing that. Doesn't mean anything." Even though the care worker was near the person's room they didn't go in to check on them. We did and saw the person had slid down in their chair and needed help to sit up. We asked staff to assist the person, which they did. However, we were concerned that staff had ignored the person's calls for assistance until we intervened.
- We heard staff sometimes used language which was not respectful. For example, referring to people as 'singles' or 'doubles' depending on the number of staff they needed. One staff member described some people as, "The noisier ones who shout all day" when telling us which unit people were on.

The lack of care and compassion some people experienced meant they were not treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- In contrast other staff were very kind and caring in their interactions with people; displaying compassion and understanding. One person said they were feeling cold and the care worker brought them a jumper and offered them a cup of tea. The person told us, "I like [name of care worker]."
- People and relatives praised the staff. One person described them as 'excellent'. Another person said the home was, "Really nice, smashing." A relative said, "Staff are brilliant, they need more money to make sure they stay. Treat my [family member] with great respect & dignity."
- Staff had received training in equality and diversity which helped them understand how to promote and protect people's rights. People's care records had sections about their preferences, beliefs and faiths. One person's care records provided information about their religious and cultural needs. Staff were on duty who could speak the person's preferred language and they had a good understanding of the person's needs.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always promoted and respected.

● Relatives told us people's privacy was respected. One relative said "Absolutely. If [family member] needs changing, they respect [family member's] privacy and shut the door." However, we found staff practices varied.
● We saw several people who were in their rooms had their doors wide open. It was not clear if this was their choice. Although some staff knocked and announced themselves before going into people's rooms, others didn't and just walked straight in. We saw one person in bed who was naked from the waist down in full view of anyone passing. The person was calling out to staff but no one took any action until we mentioned it to a care worker who asked the person if they wanted the door closing.
● Some people's bedrooms had floor to ceiling windows which looked out onto houses opposite, other bedroom windows looked onto the secure garden area and people could see into the rooms from the garden. People's privacy had not been considered. Curtains were fitted but some did not meet in the middle.

Some people's privacy and dignity was not maintained. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure staff treated people with care and compassion and maintained people's privacy and dignity.

● Visitors said they were welcomed and could visit at any time.

Supporting people to express their views and be involved in making decisions about their care
● People were given choices in their daily lives. This included when they wanted to get up, where they wanted to spend their time, what they wanted to eat and drink. One person said, said, "If I want to get up. I get up."
● However, people's care records provided little evidence to show they had been involved in making decisions about their care.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant services were not planned or delivered in ways that met people's needs.

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

- People did not receive person-centred care. People's care records were not up to date and did not reflect their individual care needs or preferences. Many of the care plans included standardised statements.
- One person's care plan stated staff were to use distraction to prevent altercations, yet there was no information about what distractions to use. The person's care plan showed they were diabetic and required their blood sugars monitoring weekly. There was no detail to say whether the person required a diabetic diet or was taking medication or what staff should do if the person's blood sugars were high or low. The nurse told us the person was on a diabetic diet and took medication for diabetes.
- Where people's care plans did contain guidance for staff this was not always followed. One person's care plan showed they often became anxious and would say staff were hurting them when being supported with personal care. The care plan stated when this happened staff were to walk away leaving the person safe and to inform the nurse in charge. We saw this did not happen. Other care records for this person showed they may be in pain when moved or transferred, yet there was no care plan for this and no consideration that the person may be in pain when they were shouting out.
- Staff told us they did not have time to look at the electronic care plans. We found some staff lacked the skills and knowledge to access information about people on the electronic care system. This meant staff did not have up to date information about people's needs and how care should be delivered.

The lack of assessing and planning care and support meant people's needs were not identified and met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure people received person-centred care and that this was reflected in their care plans.

Improving care quality in response to complaints or concerns

- Systems were in place to respond to complaints; however these were not always followed.
- The complaints log showed six complaints had been received in 2019. Five of these had been investigated and dealt with appropriately with responses sent through to the complainant. For one complaint there was no acknowledgement or response letter to the complainant.
- We also found a letter of complaint dated January 2019 in amongst other unrelated records. This was not included on the complaints log and there was no evidence to show it had been dealt with. The nominated

individual took action to deal with this immediately.

Processes in place to deal with complaints were not effective. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed actions had and were being taken to ensure complaints were dealt with appropriately.

● The complaints procedure was displayed in the service. People and relatives told us they knew how to make a complaint

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's care records identified their communication needs. One person's care plan showed they used a computer and facial expressions to communicate. Another person's care plan showed they understood English, but this was not their first language. There was a member of staff who spoke the person's first language, however the care plan gave the wrong information about the language the person spoke.
● There was some pictorial information available to people such as menus and posters.
● In the information sent through by the provider before the inspection they stated, "Where people are unable to make their needs known verbally, communication boards have been introduced, promoting independence and autonomy both while the person is in the service or out on an outing. The communication boards contain pictures of significant factors allowing a person to point out the area of need." During our inspection we saw no evidence of these being used.

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
● The provider employed an activity organiser who was very enthusiastic about their role and full of ideas about different activities and events people may enjoy. They provided one to one time with people as well as group activities. Regular events included film afternoons, gentle exercise and art projects.
● We saw people enjoyed the contact they had with the activity organiser, who was greeted with smiles. People enjoyed a singing session in the afternoon with one person playing the piano and leading the singing.

End of life care and support
● People's care records contained a section for end of life care and wishes. For one person this was well completed with details about their preferences and advanced care decisions. However, there was no information recorded in other people's care records we reviewed. This was discussed with the provider at feedback.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service was registered in April 2017 and has a history of breaching regulations. At inspections in September and December 2017 the service was rated Inadequate; issues were widespread and related to multiple breaches of regulation. Some of the same areas of concern have been identified at this inspection. In 2018, the service had improved and was no longer in breach of regulations; however, this improvement has not been sustained.
- The service was not well-led and there had been a lack of consistent and effective leadership. The registered manager took on a new role in January 2019, de-registered as the manager in February and then left in April 2019. There had been three different managers in post since January 2019, not one of whom had registered with the CQC.
- People and relatives expressed concerns about the management of the service and, when asked, did not know who the manager was. People said, "I don't know [who the manager is]. They get them, then they go" and "I don't know because it is a new one". One relative said they thought things had slipped recently. They said had not been informed about management changes and were not sure who the current manager was. They said the previous registered manager had been good and the home had been well run. Another relative, when asked about the management of the service, said, "Watch this space. Lots of different managers, [previous registered manager] was brilliant. I have had a lot of conversations with the owners who have a lot of plans. I have emailed them regarding my concerns."
- Quality management systems were not effective and provider oversight of the service was poor. Provider audits were carried out and identified issues, however there were no action plans to show who, how or when these issues would be addressed or followed up to make sure they had been completed.
- Audits carried out by managers were not always accurate. A falls analysis completed in May 2019 stated sensor equipment was installed in one person's bedroom, but we saw this was not in place. A monthly weight audit showed one person had lost 5.6kgs in four months, yet there was nothing recorded to show what action had been taken in response.
- Systems and processes did not drive forward improvement. Oversight and monitoring of accident and incidents was poor. On the third day of the inspection, managers told us only two accidents/incidents had occurred in the ten days since we last visited. When we asked to see these reports, the managers discovered there had been 11 accidents and incidents. They were not aware these had occurred.

● The provider told us they had taken action in response to issues we raised on the first two days of inspection. However, when we checked some of these had not been completed. For example, installing a sensor mat in one person's room and recording staff who were allocated to provide one-to-one support for another person.

The lack of consistent and effective leadership and robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed a permanent manager had been appointed who would be registering with the CQC and effective quality assurance systems would be put in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and relatives gave mixed feedback about how well the service engaged and involved them. Some relatives were satisfied with arrangements in place; one told us they attended all the residents and relatives' meetings. However, others told us they were not kept informed about what was happening in the home or in respect of their family member. One relative commented, "I think the communication with families is their downfall." Another relative said whenever they asked staff about their family member the staff responded, "I don't know I have just come in."

● Residents and relatives' meetings were held regularly. We saw minutes from the last one in February 2019. A further meeting had been planned for 26 March 2019, but we were told this was adjourned as no one turned up.

● The provider's PIR stated satisfaction surveys were sent out annually to people, relatives, healthcare professionals and staff. The manager did not know if any surveys had been carried out recently.

● Staff meetings were held however, the minutes showed these were not well attended. At the most recent meeting on 23 May 2019 five staff attended. Nine staff attended the previous meeting held in February 2019.

● Staff felt communication could be improved. One staff member said, "We don't know what the structure is or what's happening. It's turmoil. Don't know what's happening with the manager."

● The service worked in partnership with other agencies. Care records showed input from a range of professionals including GPs, community matrons, speech and language therapists and opticians.

The provider responded after the inspection. They confirmed meetings had been held with people who use the service, relatives and staff to inform them of management changes and provide an opportunity for their feedback.