Saffronland Homes 2 Limited

Glen Heathers

Inspection report

48 Milvil Road
Lee-on-the-solent
PO13 9LX

Tel: 02392366666
Website: www.saffronlandhomess.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Glen Heathers is a residential care home providing personal and nursing care to up to 53 people. The service provides support to older people including people living with dementia and/or a physical disability. At the time of our inspection there were 24 people using the service. Glen Heathers accommodated people in one adapted building.

People's experience of using this service and what we found
People were not always prevented from receiving unsafe care and treatment. People were at risk of harm because risks to them were not always assessed or mitigated.

Incidents including safeguarding concerns were not always recognised, reported or investigated. There were concerns about the safe management of; medicines, infection control, staffing and recruitment.

The provider had failed to make enough improvements since the previous inspection and has a track record of not providing good standards of safety. We continued to receive feedback from people and relatives which raised concerns about the safety and quality of care.

The delivery of high-quality care is not assured by the provider's system in place to assess, monitor, and improve the service. A manager is in post and we received positive feedback about their impact on the service culture. However, leadership in the service has been stretched and inconsistent which has meant progress since the previous inspection has been slow and improvements have not always been sustained.

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 inadequate (published 12 November 21)
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns about people's safety and as a result, we undertook this focused inspection. In addition, we carried out an unannounced focused inspection of this service on 13 September 2021. Breaches of legal requirements were found. The provider completed an action plan after that inspection to show what they would do and by when to improve notifications of other incidents, safeguarding service users from abuse and improper treatment, premises and equipment, safe care and treatment, good governance and staffing.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe and well-led

which contain those requirements.

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Glen Heathers on our website at www.cqc.org.uk .

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

We have identified breaches in relation to the safe care and treatment for people, staffing, safeguarding people from abuse and improper treatment, fit and proper persons employed, governance and notifying CQC of incidents.

We issued a Notice of Proposal to remove this location from the providers registration. The provider did not submit any representations against this Notice so we issued a Notice of Decision. We have now removed this location from the provider's registration. This service is no longer operational with effect from 6 June 2022.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Glen Heathers

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 Health and Social Care Act 2008.

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
This inspection was carried out by 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.

Service and service type
Glen Heathers is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Glen Heathers is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. A manager had been appointed and we were told they would be applying to be the registered manager. We have referred to this person as the manager throughout the report.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used information from on-going monitoring of the service such as action plans and meetings. We used all this information to plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers 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.

During the inspection
We spoke with nine people who used the service and nine relatives about their experience of the care provided. We spoke with 14 members of staff including agency workers, the manager, the training and compliance manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found and we referred our concerns to the local authority.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating has remained the same: This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure risks for people were appropriately assessed and acted on. This was a continuing breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At the last two inspections we found risks to people were not always assessed or managed appropriately and this meant people were at risk of unsafe care and treatment. This remained a concern at this inspection. For example, one person had been assessed as at risk of choking and a SaLT (Speech and Language Therapist) assessment had concluded they required thickened drinks. The person refused to have thickened drinks. Their care plan stated the risk was to be managed by assisting the person with drinks and keeping drinks out of their reach. On the first day of our inspection we observed the person had three drinks within their reach. We raised this with the manager and when we returned to the home on 22 March the drinks had been removed. However, when a health professional visited the person on 23 March, they informed us drinks were left on the table potentially within the persons reach. This meant the person would be at risk of choking as safe guidelines were not followed.
● People told us, and records confirmed risks to people associated with their continence needs were not safely managed. During day one of our site visits we heard a person calling out to staff for assistance to change their continence aid which records confirmed had not been changed for eight hours. We heard the person tell staff they had used their call bell to alert staff earlier, but a carer had come in and turned their call bell off and not come back. This person's care plan identified they were at high risk of pressure sores and moisture lesions due to being doubly incontinent. On day three of our site visits we spoke to them about their continence aid support and they said "It's OK but I didn't have a change this morning I was still in the extra-large pad from last night, it was sopping wet and I had a big motion." Records showed they had not had continence support between 12 midnight and 11am on that day. We found several examples of records which showed people had been left for long periods without continence aids being changed.
● Elimination records (records of urine and bowel movements) for four people were of concern. There were periods when no bowel movement was noted for a period of five to six days. These people were at risk from constipation and care plans stated after three days with no bowel movement this should be assessed, and medication considered. There was no record of an assessment or of medication being given or considered. We asked a nurse about this who told us elimination charts should be monitored by care practitioner staff. Two care practitioner staff told us they did not monitor this information. This meant people were at risk of ill

health from the effects of constipation.
● Risks to people from malnutrition were not safely managed. One person had lost 6.4kg when they were last weighed in March 2022. Prior to this they had been weighed once in four months in December 2021 when they had lost 2.5kg. The GP had been contacted and prescribed supplements, advised fortified food and observation. There was no risk assessment in place which detailed how the risk of malnutrition was to be managed. Food charts to monitor intake were not completed to show what and how much the person had eaten which meant their progress could not be evaluated effectively. We found other examples where risk assessments and monitoring records of nutritional intake for people at risk of malnutrition were not completed or reviewed and they had lost weight.
● The treatment, monitoring and evaluation of skin injures was not consistent. Photographs were not taken of wounds as instructed in the care plans for two people. Two nurses gave us different accounts of a wound status and records showed conflicting treatment plans. We discussed this with a nurse who implemented a daily record of wound management. For some injuries described in peoples care records there was no record of the action taken to investigate or monitor these injuries. This meant people were at risk of harm from poor wound management.
● One person had experienced five falls since February 2022. There was no risk assessment for falls in their care records. Their mobility care plan included some information about falls but did not refer to recent falls or remedial actions. A chair sensor cushion had been put in place however, the clinical audit stated they refused to use this, and a risk assessment and mental capacity assessment was to be implemented. We asked to see these, but staff could not find them. The lack of a risk assessment with remedial actions to guide staff as to how to mitigate the risk of falls meant the person was at risk of injury from further falls.
● For people at risk of pressure injuries who were cared for in bed turning charts were in place to mitigate the risk to them of developing pressure injuries. However, these records did not show people were turned at the frequency instructed in their care plans. We could not be assured plans to mitigate the risk to people from developing pressure injuries were acted on.
● We observed two people cared for in bed and at risk of falls did not have their call bells within reach on the first day of our inspection. On our third visit the call bell was again out of reach for one of these people. This meant they would not be able to call for assistance should that be necessary.

The failure to ensure risks for people were appropriately assessed and acted upon was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider confirmed they had taken action to address the risks we found. However, following these assurances a health care professional visited the service and found some of these risks had not been addressed.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure effective systems were in place and operated to investigate allegations of abuse and safeguard people from abuse. This was a breach of Regulation 13 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 13

● Following the previous inspection, the provider and manager had worked with the local authority to address outstanding safeguarding investigations and improve their system for managing incidents and allegations of abuse. However, we found some incidents which had not been identified as potential

safeguarding concerns and had not been investigated to ensure people were protected from abuse.
● For example, we received information of concern from a member of the public concerning a person found stuck in mud in their wheelchair some distance from the service. The person was unable to state their name and address. When the member of public made enquiries at Glen Heathers about a missing person staff were unaware of this. The person had been away from the service for at least 30 minutes. An incident report stated a staff member had accompanied them outside to have a cigarette and then left them, contrary to their care plan, and neglected to physically check the person was OK. This person had needs which meant they would be at risk of harm without staff support in the community. We referred this incident to the local authority safeguarding team. When we spoke to the manager about this four day's following the incident, they were unaware of this because staff had failed to identify this as a safeguarding concern.
● A body map showed bruising to a person's forearm and a second person had a note in their behaviour record which stated, 'bruises on left leg which are red and round like.' There were no records to show where these bruises had come from or if they had been investigated. On checking there were no incident reports. We spoke to a carer about this and they said, "When bruising is found we document on body map then report to the nurse and the nurse will decide what to do if there needs to be attention." A nurse said, "It depends [if all bruising is investigated and recorded as an incident] carers should come and tell us as well [as body map] if they can explain it then it's not an incident". The failure to recognise possible abuse, and the lack of reporting, records and investigation into unexplained injuries meaning people were at risk of recurring harm because the cause of the injuries had not been established.

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

● We observed bed rails were in use for a person due to their risk of falls. Information in the care plan indicated this person lacked the capacity to make this decision. Their moving and handling assessment stated they did not like to have bed rails, although we observed they were in use. A risk assessment had been carried out which had not considered less restrictive alternatives and did not include the person's view or consent. This risk assessment stated there was a 'contraindication' for using bed rails which was not clearly identified. Bed rails are restrictive, and their use should be assessed under the MCA using the best interests process when the person lacks the capacity to make this decision. There was no evidence this process had been followed.

An effective system was not in place to prevent the abuse of service users. The provider had failed to apply a best interest process under the MCA for a restrictive practice. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● Following the inspection, the provider confirmed they had implemented a daily incident reporting system for management oversight. This was to ensure incidents were investigated and appropriate actions taken.

Staffing and recruitment

At our last inspection we found that the provider had failed to ensure appropriate numbers of skilled, competent staff were adequately deployed to meet the needs of people. This was a continued breach of Regulation 18 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 18

●Following the last inspection, the provider had not used a dependency tool to determine staffing levels in the home. The manager told us they observed whether there were enough staff. The provider reported there was 'daily monitoring' of staffing needs carried out. We continued to receive concerns about staffing levels in our conversations with people, relatives and staff.

● Feedback from relatives included comments such as "No [not enough staff], a lot of staff have left…The staff are not bothered to shave [person] every day. [person] loves her hair being washed but now she has greasy hair because it hasn't been washed. The lady who used to wash her hair has suddenly left," "They have been very short staffed, so [person] has to wait to be hoisted into a chair," and, "Definitely not, [enough staff] especially at night."

● A staff member said "[staffing levels] are hit and miss." They went on to say staff were not always able to meet people's needs due to staffing levels and gave an example of turning not being completed in line with people's care needs. Records confirmed this. Another staff member said more staff were needed because call bells were "very busy" and there were not enough staff "To be able to spend time with people." Two staff members said they thought there were enough staff but felt there were difficulties at times caused by the number of agency staff on shift who required more direction and training.

● People's comments included; "Staff are infrequent, and you can't always get them, a normal day you wait two hours." We asked, why staff were needed, and the person told us, "To go to the toilet, all kinds of things." Another person told us they got 'told' off by staff and they didn't always answer the call bell when they pressed it. They said it had taken so long for someone to answer the buzzer, they had soiled themselves and had to have their bedding changed, and this happened twice. Records of their continence support showed there were long gaps on some dates. A third person told us about an incident when they had been disturbed by noise and said "I had to ring the office on my phone twice as nobody came…buzzer was not answered…I was almost at the point of calling 111."

● We asked the provider whether call bell response times were audited. They told us they had this facility but "Had not done one of late." This meant the provider could not be assured call bells were answered promptly.

● On the first day of our inspection there were five care staff on duty and one nurse, this is the usual level of staffing confirmed by the rotas and the manager. On the second day of our inspection there were seven care staff and two nurses which according to the staff rotas was higher than usual and the manager told us this was due to an overbooking of agency staff. On the first day we observed there were times when staff were not always present in the dining room during lunch or in the lounge. A staff member told us "You need someone in the dining room as [people's names] you must watch, with more staff we can have two staff in there." On the first day during lunch there were two staff in the dining room which quickly became one, and they were not always present which meant people were left unattended.

● Rotas showed there was a very high use of agency staff. Staff told us agency staff were of mixed ability and people and relatives feedback supported this. A relative said "There is a complete diversity of capability. The regular staff are caring, and the agency staff have little knowledge and show disdain for the person they are caring for… the agency staff have no ownership… and the patients don't know them." The provider had attempted to use consistent agency staff as much as possible. However, we found not all these staff had received an appropriate induction, training or competency assessment to evidence they were suitably skilled to carry out their role.

● Due to the feedback we received, the records which showed people had not always had their needs met in a timely way, our observations and the lack of a systematic approach to determine the numbers of staff, competence and skills required to meet people's needs; staffing continued to be of concern.

The failure to ensure appropriate numbers of skilled, competent staff were adequately deployed to meet the

needs of people was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Following the inspection, the provider submitted a completed staffing dependency tool which showed a staffing level of seven care and nursing staff in the morning and six care and nursing staff in the afternoon would provide enough staff to meet people's needs. The provider has also stated new agency staff will receive an induction consisting of two days shadowing other staff, competency assessments and an English language test.

● People were not always protected from the employment of unsuitable staff because recruitment checks were not always carried out safely. Risks to people from staff who were employed without satisfactory evidence of conduct in a previous health or social care role were not always appropriately managed.
● The provider was using a high number of agency staff. The provider had not seen the original identification documents, or other recruitment checks for these staff and were reliant on the information supplied by the agency. We looked at some of these records and found photographic evidence was not clear, passport and driving licences had been photocopied and were often very poor copies and in some cases we were unable to see how the person could be recognised from the photo provided which meant their identify could not be verified.
● Some agency staff profiles stated the employee had completed training in several topics. For example, for one employee the certificate provided showed this was 16 topics covered in one day. This had been completed in 2019 and there was no record of this having been renewed or updated. The provider did not always carry out competency checks of agency staff. Of the six regular agency nurses used by the service only one nurse had a medication competency assessment. This meant the provider could not be assured these staff had the competence, skills and experience to fulfil their role.
● Two staff had been employed without satisfactory evidence of their conduct in a previous health and social care role. For one staff member a risk assessment had not been put in place to protect people whilst assessing the staff members suitability. For another person, a risk assessment was in place but actions to mitigate the risk had not been followed. When we asked to see their supervision records [as part of their employment risk assessment] the manager could not locate these. The manager had expected these to be completed by the clinical lead, but these had not been done. This meant people could be exposed to risks from unsuitable staff.

The failure to operate robust recruitment checks in line with Schedule 3 of the regulations and to check staff have the competence, skills and experience necessary for their role was a breach Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Following the inspection, the provider stated they will request original identification, interview all new agency staff and competency checks will be carried out with all agency staff.

Using medicines safely
At our last inspection we found that the provider had failed to ensure medicines were managed safely this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were prescribed medicines to be taken 'as required' these are referred to as PRN medicines. For

example, medicines such as laxatives, pain relief and medicines to manage anxiety or agitation. Not all PRN medication was managed safely. Protocols to guide staff as to their safe use were not always personalised or detailed enough and some were not in place at all.

● For example, one person was prescribed a medicine to help manage agitation. Their Medicines Administration Record (MAR) showed for the period 28 February – 8 March 2022 they were given this medicine regularly twice each day. There was no PRN protocol in place to describe what actions staff could try before giving this medicine. We raised this with a nurse and on our second visit a PRN protocol had been produced but this did not include information of what to try before giving the medicine. There were no notes as to why this had been given on those dates. There was a risk this medicine could be used to control people's behaviour.

● One person who was prescribed an oral gel PRN to treat low blood sugars had a PRN protocol in place which contained no information about the signs and symptoms to prompt use or the expected outcome. Another person prescribed a laxative PRN had a PRN protocol in place which did not say when to give the medicine and was not personalised. Another person had PRN laxative and pain relief and there were no protocols in place.

● Medicines applied to the skin (topical creams) were not always managed safely. A person was prescribed a topical cream for a skin condition. Their prescription stated this was to be applied twice per day. There was no information on the MAR to say where the cream should be applied, between the 28 February and 9 March 2022 it had been applied six times. We found several other examples of incomplete records for people prescribed topical creams to prevent skin injuries or deterioration in skin conditions. Two people prescribed a topical medicine had no MAR chart in place so we could not be assured this was being applied.

● On one occasion a person's insulin administration record stated they were not given their daily insulin because they refused a blood glucose test. There was no information about any action taken to address this or guidance for staff to follow in these circumstances on what the impact could be for the person. The person's blood glucose reading was sometimes higher than the safe range described in their care plan and this stated the GP should be contacted in these circumstances. There were no records of the GP being contacted. Following the inspection, the provider has confirmed this will be discussed with the GP.

A failure to ensure medicines were managed safely was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection we found the provider had failed to ensure effective infection prevention and control measures and a clean environment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We observed some areas of strong malodour and some areas were not clean, observed outside the kitchen, windowsills and corridor. On the first day of our inspection we observed cluttered areas within the home which could increase the risk of spreading infection.

● Clinical waste skips did not lock, and one was permanently wedged open. There was loose PPE in the bottom of the skip. We observed discarded PPE in the garden which the manager then removed. We also saw a pair of discarded gloves within the home in a communal area. Used PPE presents risk to people from

the spread of infection.
● We observed a staff member leaving the sluice room and they failed to shut and lock the door behind them. This has been raised at the previous two inspections. This is important to prevent people from being exposed to risks in this area.
● On day one of our inspection there was a large TV Ariel in the garden which we were told had blown down in a storm. This would present risks to people if they used the garden and the incident had occurred three weeks earlier. We noted other risks such as a hole in the floor, an unlocked kitchen door and a PPE trolley left in a communal area. These concerns all presented risk of harm to people.

The failure to ensure the safety of the environment and prevent the risk of the spread of infection was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

The providers visiting arrangements were in line with government guidance.

Learning lessons when things go wrong

At our last inspection the failure to ensure systems and processes were in place and operated effectively to learn lessons and drive improvement to the safety and quality of the service was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement has been made and the provider was still in breach of Regulation 17.

● We were not assured lessons were learnt when things went wrong. As described above there were incidents which were not recognised as requiring investigation. This meant improvements to prevent a reoccurrence would not be identified or established.
● We have identified several repeat breaches of regulation and this was because not enough action had been taken or sustained to show lessons learnt were embedded into the service.
● The provider has been supported by the local authority and clinical commissioning group to make improvements. Progress has been reported on action plans and shared in meetings. There continued to be actions taken which on checking had not been sustained. Such as; the falls risk assessments, incident reporting and record keeping.

The failure to ensure systems and process were in place and operated effectively to learn lessons and drive improvement to the safety and quality of the service was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection we rated this key question Inadequate. At this inspection the rating has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to notify CQC about significant events without delay. This was an ongoing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

● We had received information from the local authority about allegations of abuse which had been investigated under their safeguarding process. We discussed these incidents with the manager because we could not find information to say we had been notified of all these incidents as required in the regulations. These incidents had occurred before her employment; however, she was unable to check the records relating to this period because the system to retain safeguarding notifications had not been used after June 2021. We identified five allegations which had not been notified to CQC since the last inspection. This meant we could not effectively monitor the safety of people using the service.
● The manager and provider had been working on a backlog of safeguarding investigations as these had not been investigated and completed by the previous manager. They had implemented a system to check incidents were appropriately reported to the local authority and CQC. However, this depended on staff identifying incidents to be brought to the attention of the manager and as described in safe we found this was not always effective.

The failure to notify CQC of any allegation of abuse in relation to a service user was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection we identified the provider had failed to operate effective systems to assess, monitor and ensure the safety and quality of the service. This was an ongoing breach of Regulation 17 of the health and Social care Act 2008 (regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 17.

● The provider had systems and processes in place to assess, monitor and improve the quality and safety of the service. However, these systems were not effective and had failed to pick up all of the issues we identified during our inspection.
● A monthly clinical analysis was produced by the clinical lead. This report was shared with the

management team to inform them of key clinical information and the actions taken to address concerns, such as weight management. We found this audit did not contain accurate information and some actions had not been taken as stated. For example, in the most recent audit, the person with the most weight loss was not included on the report and three other people who had lost weight and were not included on the audit. This meant these people's health could not be effectively monitored.

● The providers action plan stated 'Ongoing there will be a monthly visit to review the clinical audit. This includes wound care, fluid and nutrition, weights.' However, there was no evidence this had taken place and a nurse told us, "Sometimes I get an email with comments for example, 'you have written this, what do you need to do about it?' they [recipients] ask for more info – last month no feedback"

● We identified a person had experienced five falls in the last two months. Following these falls records stated the action for staff to take was; 'risk assessment to be implemented' and a 'mental capacity assessment' to be completed. We requested to see these assessments and neither of these were available. This meant actions were not taken to mitigate future falls. Additionally, further records were not available as stated in care records, including photographs of wounds. The lack of accurate information about risks and actions taken to mitigate risks meant the provider and manager were unable to properly assess and mitigate risks to people.

● As highlighted in the safe domain people commented on having to wait for care when using their call bells. We noted within the provider's development plan dated January 2022 the following comment; 'Call bell system now has log facility installed to help identify response time. Proven to be effective.' However, audits of response times had not been carried out.

● Other monitoring was irregular or not completed. The last fluid audit available was dated 17 January 2022. Two care staff who we were told by the clinical lead had responsibility for checking the elimination and food charts told us they did not.

● Issues identified through the provider's governance and audit systems had not always been actioned. For example, we reviewed monthly reports for December 2021 and January 2022, completed by the manager and shared with the provider. These reports gave reference to gaps in monitoring information, but no improvement had been made or sustained. Additionally, the action plan completed by the provider in February 2022 stated, 'Competency records are now available for all staff, including agency staff,' however, not all of these had been completed when we requested evidence to demonstrate this had been done.

The failure to operate effective systems to assess, monitor and improve the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider has implemented a daily incident reporting tool which they say, "Will ensure notifications are sent in a timely manner and that risk management and safety for the person can be planned and implemented."

● The location has a condition of registration to have a registered manager. A manager was in post and was planning to apply for registration.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our previous inspection the provider had failed to ensure feedback was appropriately acted upon and this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 17

● Feedback from people and relatives had been gathered in November and December 2021. There had been some analysis of this information with some trends and actions identified. However, actions had not been taken as described. For example; the report noted 'some residents are still highlighting that they are having to wait to be washed and changed. One resident also highlights that they are kept waiting when they press their call bell.' One person had stated 'Sometimes when I press the call bell they don't come – even in an emergency.' The action identified was 'Call bell log facility to be available to enable checking of response time.' This had not taken place and people continued to tell us about these issues. Relatives told us they had not received any response or information related to their feedback.
● All the respondents said they did not enjoy living at the home with three of the five respondents saying they did not feel safe. There were no actions identified to explore or address this feedback further. Of the nine relatives we spoke with, five told us they did not feel their relative was safe, or entirely safe. This was because of incidents their relative had experienced. Safety continued to be of concern to people and relatives.
● We were not assured people's complaints were always acted on appropriately. Care notes contained a complaint from a person, and it was not clear if this was investigated or responded to. In the notes staff had advised the person to 'stop thinking negatively'. Another person told us about a complaint they had raised regarding noise and disturbance on several occasions for some time. We spoke to the provider and training and compliance manager about this and whilst they had taken some action, they said they "Were at a loss with how to proceed.' No formal complaint process had been opened. This is important to show the complaint has been properly investigated and responded to and the complainant knows how to proceed if they remain dissatisfied.

The failure to ensure feedback was appropriately acted upon and this was a continued breach of Regulation 17 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

At our previous inspection the provider had failed to ensure the environment was safe and well maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made and the provider was no longer in breach of regulation 15.

●Some improvements had been made to the environment and were ongoing at the time of the inspection. Those areas which required attention were known to the provider and plans were in place to address these.
● We did identify some safety risks in the environment, and we have addressed these in the safe domain.
● We received positive feedback about the impact of the new manager from relatives, people and staff. Staff told us there was a more "positive atmosphere" and they felt listened to by the manager. A person said, "The manager is lovely" and relatives comments included; "The manager is very helpful" and, "[manager] goes around each morning to see clients."
● Leadership resources in the service were stretched. The manager had been focused on addressing safeguarding issues which had not been completed under the previous manager. There had been changes in the clinical leadership and this role was now being supported by an agency nurse. Reliance on agency staffing was high. Progress on action plans had been limited by this. Strategies to implement and sustain changes had not been embedded such as, staff supervision and consistent and reliable monitoring/reporting. Therefore, the quality of care people received continued to be inconsistent.

● We received mixed feedback from people and relatives about the quality of care people received. Some people told us they were 'unhappy' in the home, others said they were cared for well by kind staff. Relatives comments included "[person] likes living there although it doesn't feel like a home. It feels like a waiting room. With effort it can be turned around." Another relative said, when asked about improvements, "Long way to go." A third relative said, "The current management is very good. Things have improved."
● We observed some kind and caring interventions by staff, we also noted some interventions when staff did not acknowledge or communicate with people they were supporting. People told us they received inconsistent care. For example; when asked about continence support a person said, "Some too much some not enough, some are too restrictive." Another person said, "Agency carers haven't got a clue… they [agency] just don't comprehend what to do."

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 manager and provider understood their responsibilities under the duty of candour.
● Notifications of significant incidents submitted showed the duty of candour was considered and confirmed it was acted on.
● Relatives we spoke with whose relatives had experienced an incident relevant to the duty of candour told us they had been informed of it.

Working in partnership with others
● The local authority and care homes team had continued to work with the service following our previous inspection. There had been some positive feedback about progress made on the action plan agreed with the local authority. However, the local authority continued to find improvements made had not been sustained. During our inspection we were not assured recommendations made to improve the quality and safety of the service had been embedded, as detailed in this report.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The provider had failed to notify CQC of allegations of abuse in relation to service users. Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (1)(2)(e)

The enforcement action we took:

We issued a Notice of Decision to remove this location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to ensure risks for people were appropriately assessed and acted on. The provider had failed to ensure medicines were managed safely. The provider had failed to ensure the safety of the environment and prevent the risk of the spread of infection. Regulation 12(1)(2)(a)(g)(h)

The enforcement action we took:

We issued a Notice of Decision to remove this location from the 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 How the regulation was not being met: The provider had failed to operate an effective system to prevent the abuse of service users. Regulation 13(1)(2)

The enforcement action we took:

We issued a Notice of Decision to remove this location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider had failed to ensure systems an processes were in place and operated effectively to learn lessons and drive improvement to the safety and quality of the service. The provider had failed to operate effective systems to assess, monitor and improve the service. The provider had failed to ensure feedback was appropriately acted upon. Regulation 17(1)

The enforcement action we took:

We issued a Notice of Decision to remove this location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider had failed to operate safe recruitment checks in line with Schedule 3 of the regulations and to check staff have the competence, skills and experience necessary for their role. Regulation 19(1)(2)

The enforcement action we took:

We issued a Notice of Decision to remove this location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure appropriate numbers of skilled, competent staff were adequately deployed to meet the needs of people. Regulation 18 (1)(2)

The enforcement action we took:

We issued a Notice of Decision to remove this location from the providers registration.