WCS Care Group Limited

Attleborough Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Attleborough Grange is a 'care home', which provides accommodation and personal care for up to 32 older people, some of whom are living with dementia. The home has two floors, with four 'households' – Abbey and Newdegate are on the ground floor and Chilvers and Griff are on the first floor. People had their own bedrooms, some of which had en-suites. People had access to communal lounge and dining areas and an outside garden area. At the time of our inspection there were 31 people living at Attleborough Grange.

People's experience of using this service and what we found
Since our last inspection visit, we had received concerning information that indicated people did not always receive personalised care, specially around staffing levels, and risks, including falls management. There had been a change in registered manager since our last inspection, the new manager had commenced their role during April 2019 and become registered with us on 23 September 2019.

During our inspection visit, people, relatives and staff told us they had concerns about staffing levels. Day and night-time care staff felt the provider's allocated staffing levels were not always sufficient to meet people's identified care needs in a personalised way. Daytime care staff did not feel always supported by duty care managers on shift.

Risks associated with some people's care were not managed safely. People's health conditions had not always prompted risk management plans to be in place. The provider's call bell system was not working correctly and this posed increased risks of harm and injury to people because staff did not receive a 'beep' when help or support was required. The provider had identified the problem with the call bell system and called an external company to address the issue. However, this had not been resolved in a timely way and whilst problems presented, additional measures to reduce risks had not been taken by the provider or registered manager. Following our inspection, measures were put in place and a review of the system commenced.

Medicines were available to people, however, when some medicines were given covertly (hidden in food or drink) there was no information from a prescribing GP or pharmacist to show safe ways for this to be given. The provider had not ensured they had the legal authority, under the Mental Capacity Act 2005, to give medicines in this way. The provider did not always ensure night shifts had a staff member trained to give medicines to people.

Improvement was needed to ensure the cleanliness of the home was maintained.

Overall, people and their relatives were complimentary about care staff and the kindness they demonstrated. People and relatives were positive about the range of activities that took place, but said more were needed to prevent social isolation. Staff's approach was task led which impacted on people not having maximum choice and control of their lives or being supported in the least restrictive way possible

and in their best interests. The provider's systems in the service did not always support this practice.

There were some systems in place for people and relatives to give their feedback on the service, such as 'relative and resident meetings'. The provider had a system to deal with complaints, however, whilst relatives felt they were listened to, they did not always feel issues were resolved to their satisfaction.

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

Rating at the last inspection
The last rating for this service was Good (published 15 November 2018). During this inspection visit, we found the safety and quality of the service had deteriorated and some people's care outcomes were not of a good standard. The service is now rated Requires Improvement. We identified breaches of the Health and Social Care Act 2014 (Regulated Activities):

Regulation 11 Need for Consent
Regulation 12 Safe care and treatment
Regulation 17 Good governance
Regulation 18 Staffing

Why we inspected
The inspection was prompted in part due to concerns about staffing levels, notifications we had received from the provider about specific incidents, and the overall management of the home. A decision was made for us to inspect and examine those risks.

We found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our inspection programme. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Attleborough Grange

Detailed findings

Background to this inspection

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

Inspection Team
Two inspectors carried out this inspection.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and the quality and safety of the care provided. There had been a change in registered manager since our last inspection and the new manager had commenced their role during April 2019 and registered with us on 23 September 2019.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. This included details about incidents the provider must notify us about, such as serious injury and abuse. We had received concerns from relatives about the safety of care at the service, low staffing and lack of stimulation for people. We also sought feedback from the local authority. The local authority had undertaken a visit in October 2019 and found areas where improvements were required. These related to people not always receiving the support they needed because staff were involved in tasks elsewhere, staff not always being able to summon help from other staff and the provider not always working within the Mental Capacity Act

2005. We used all the information to plan our inspection visit.

During the inspection
We spoke with seven people and 11 relatives. Some people living at the home could not give us feedback due to their complex needs. We spent time with people in communal areas, observing interactions and support they received from staff. We spoke with 13 members of care staff (including night staff), the activities staff member, one cleaner and the housekeeper, the cook, the care manager, a duty manager, the registered manager, and the provider's service manager and director of delivery. We reviewed a range of paper and electronic records. This included a review of six people's care plans, risk management plans, multiple medication records, daily checks and people's food and drink records. We also looked at records relating to the management of the home.

Requires Improvement

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 Good. At this inspection we found the rating had deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Important information about managing risks of harm or injury was not always available for staff to refer to when needed. For example, one person had a crash mat to mitigate the risk of injury if they fell from bed. We saw this was positioned towards the bottom end of their bed, leaving a gap at the head of the bed. One staff member told us, "I think it's meant to be like that because they dangle their feet out." This person had recently sustained head and facial injuries following a fall from bed. The registered manager confirmed the person's crash mat should be positioned to give full protection to their head; should they fall from bed. But this detail was not included in the person's care record. The director of delivery took immediate action to ensure tape was affixed to the carpet to guide staff and the registered manager added information to the person's risk management plan.
- The call-bell system at the home was not working correctly. Staff told us they were unable to ensure people were kept safe from harm because the system did not always alert them when people required support. A night staff member told us, "The hand-held devices don't work properly, we've reported this, but action by managers is very slow. It's a big risk, I really worry because [Name] likes to walk about at night and if they opened the fire door, we'd get no alarm 'beep'. They could go outside, there's a brook in the garden, so we really worry when the devices don't work." Whilst the provider had reported faults with the system, they had not increased staffing levels to ensure a staff presence on each 'household' throughout the night to reduce risks and support staff to undertake additional safety checks on people.
- Where people had an identified risk of falls, the provider had placed pressure sensor mats to alert staff when the person needed support. However, because of the identified fault with the call bell system, when sensor mats were activated, they did not always send an alarm 'beep' to the staff's hand-held devices. One relative told us, "My family member has previously fallen from bed, but this sensor mat does not work."
- Some people were at risk as having or developing sore skin. Pressure relieving equipment, such as airflow mattresses were in place, however, daily checks to ensure these were set correctly were not always effective. Of the four we checked, two were set incorrectly which meant people did not receive the desired pressure relief. For example, one person's airflow pump was set at 150kg and should have been set between 55-60kg.
- Records did not always demonstrate people were repositioned in their bed to relieve pressure on their skin, as care plans directed. For example, one person who had sore skin should have been repositioned every two hours. However, on 13 October 2019, it was recorded they were re-positioned at 11.02 and not again until 16.14. Staff told us they tried to prioritise care tasks, but some were delayed due to them offering support elsewhere. This meant people were not always repositioned when needed which increased risks of their skin becoming damaged.
- The provider had a system for staff to report accidents and incidents. Whilst some individual actions were taken, these were not always in a timely way. For example, one person had fallen 14 times, to date, during

2019. The registered manager had not requested a referral to the falls-clinic or occupational therapist for guidance on equipment that might reduce risks and mitigate injuries sustained. The registered manager told us they had not been aware they were able to do this until informed by commissioners during a recent visit in October 2019. The provider had not ensured the registered manager's analysis of accidents and incidents was used as effectively as it could have been to ensure learning was identified and risks of reoccurrence minimised.

Preventing and controlling infection

● Staff had completed infection control training and had personal protective equipment available to them. Staff used gloves to reduce risks of spreading infection, for example, when undertaking personal care. However, there was a potential risk of cross infection because staff did not use aprons when preparing people's breakfasts between personal care tasks.

● On the day of our inspection visit, there were no unpleasant odours in the home. However, one relative told us they had noticed a deterioration in the "freshness of the home". They told us, "When my family member moved to live at the home, it always smelt fresh when I visited. But, over the past few months there is sometimes a urine smell, it's not as fresh as it used to be."

● On the day of our inspection visit there were insufficient housekeeping staff on shift to clean the home, according to the provider's schedule of agreed housekeeping tasks. The provider's allocation of three housekeeping staff working five hours did not always happen. One staff member told us, "Cleaning tasks don't always get done, because it's impossible to do them, such as deep- cleans and some rooms just don't get cleaned."

● One person pointed out their bedroom carpet that was covered in food debris from the day before. This person said, "Look at that, it's a disgrace." We saw some areas were dusty and some carpets in people's bedrooms were visibly stained.

● The provider's staffing records showed housekeeping staff were used to support care staff when the provider's assessed allocation of a total of seven care staff for the home, fell to five or six. The registered manager confirmed lost cleaning hours were not routinely made up by additional housekeeping staff another day. This meant cleaning tasks were not always completed and levels of cleanliness were not maintained.

Using medicines safely

● People had their prescribed medicines available to them and were only given them by staff trained in safe medicines management. However, we were told there had been numerous occasions when there was no medication trained staff member on shift at night. This meant if a person needed 'when required' medicines for pain, for example, these would be significantly delayed until an on-call manager was able to go to the home. A staff member told us, "I reported concerns to our head office, and one top manager acted to ensure a specific night shift was covered." However, following our inspection visit, another staff member told us, "The registered manager has told us, this week, it is acceptable for there to be no medicine trained staff member on at night." We shared our concerns about people not having immediate access to their prescribed medicines with the provider's director of delivery. They assured us they would investigate this further.

● Some people were prescribed 'when required' topical creams. One person was prescribed a barrier cream for sore skin. However, their Medicine Administration Record (MAR) recorded staff had not always applied their cream and there was no explanation given about why this was.

● Staff did not always follow safe practices for the administration of medicines. Staff told us they used spoons to crush medicines for two people because no pill crusher was available to them. One staff member told us, "One of the duty managers told me to use spoons." Following our feedback, the registered manager assured us a pill crusher would be made available for staff to use.

The above concerns were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Staffing and recruitment

● Prior to our inspection visit, we had received concerns from relatives who felt there were not enough staff on shift to care for people safely. During our inspection visit, we received similar concerns from people, staff and relatives.

● There were insufficient staff on shift. We received negative comments about staffing levels from people which included, "They are very, very short staffed," and, "We could do with more staff, it can be a while before staff come around and check on us." Relatives comments included, "The home operates on minimal staffing levels." And, "Staffing levels don't allow my family member to have their shower in the mornings." One relative told us, "It is often hard to find staff, once I couldn't find anyone to tell them I was taking my relative out."

● All staff spoken with told us there were not enough staff on either day or night shifts to safely care for people. One staff member told us, "We definitely need more staff." Another said, "We are very stressed due to the lack of staff, we don't have time to spend with people."

● Night-time care staff had non-care tasks allocated to them. One staff member told us, "We are expected to do cleaning and the laundry. Managers say prioritise people, but then if the other tasks are not done, we get moaned at. There are only three night staff for the home, it's not enough."

● On the afternoon of our inspection visit, we observed three staff on the first floor covering two 'households'. At one point, one staff member was supporting people with their medicines, another had gone to the kitchen to prepare the teatime trolley which left one staff member to meet the care and safety needs of 16 people. Staff told us this was not a 'one off' and gave us examples of people having to wait for care and support. One staff member told us, "Every household has people who require support from two staff for hoisting, personal care or due to behaviour that can challenge. But, there are not even two staff allocated to every 'household' and even when there is, if one staff member is doing medicines, there is no one to give the support when needed."

● The registered manager told us they had experienced some "staffing challenges" with sickness and these were being addressed. The care manager told us, "We are really struggling to cover the rota with the current staffing levels." The registered manager told us they believed duty managers supported care staff when needed, however, staff told us this did not happen.

The above concerns were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

● We did not look at recruitment checks on this inspection because we had no concerns about the provider's system to ensure staff's suitability to work at the home.

Systems and processes to safeguard people from the risk of abuse

● Staff had received training in how to safeguard people from the risk of abuse and demonstrated an understanding of safeguarding principles. Staff gave us examples of types of abuse that said they would report any concerns to management and 'whistle-blow' to external organisations such as CQC or the local authority if needed.

● The registered manager understood their responsibilities in reporting specific incidents to us, commissioners and the local authority.

Requires Improvement

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 available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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, which they were.

● The provider did not consistently meet the requirements of the MCA. Staff told us they crushed, and disguised medicines with food or drink, for two people. The registered manager had not ensured they had the legal authority for staff to do this. During a recent local authority visit, commissioners had identified this to management. We found no action had been taken to discuss this with the person's GP to gain the authority required to give medicines 'covertly'.

The above concerns constituted a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11, Need for Consent.

● People's capacity to make decisions had been assessed and some 'best interests' decisions had been made with the involvement of relatives, staff and health care professionals.
● However, information about people's legal representatives had not always been checked and documented. For example, staff told us one person's relative had enduring power of attorney for their health and welfare decisions but there was no evidence of this or how they were consulted about decision making on behalf of their family member.
● Care staff understood the importance of gaining people's consent when performing care tasks and explaining what was happening. For example, before supporting them with personal care.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional and hydration needs were met. People were offered choices about what they ate and drank, however, this was in advance of mealtimes. This meant people with confusion, short-term memory loss or dementia were not offered a visual choice at the point of service.

● People enjoyed their lunchtime meal and staff showed patience and kindness when assisting people with their meal. Some people also had adapted tools to assist them to drink independently, such as specialist cups, which promoted people's dignity and independence.
● However, people and relatives gave us mixed feedback about the variety of the food offered. On the day of our inspection visit one person, who could not express any choice about their food, was brought pre-prepared mashed potatoes for their evening meal. Their relative said, "This is simply not good enough." They explained, "I bring food in on a daily basis to supplement [Name's] diet, as they are very slim and frail."
● People's weight was monitored, and referrals were made to dieticians when needed. However, the provider missed opportunities to increase calorific intake for those people with low weights, or with sore skin who would have benefitted from additional calories to promote healing in line with best practice. No high calorie snacks were prepared or offered. Following our feedback, the registered manager took immediate action to provide staff with information about eight people who required additional calories and assured us high calorie snacks would be offered.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had access to GPs and were referred to healthcare professionals when concerns were identified by staff.
● Improvements were needed in communication between staff and visiting district nurses. Staff did not always know which people were being supported by the district nurse team or what guidance they should follow. For example, where people were having their sore skin treated by district nurses, the home had not implemented detailed skin integrity care plans to give continuity of care.
● Staff told us two people had been supplied with special protective footwear to protect their skin. Whilst we saw both people were wearing their footwear, staff said they had not been given any guidance about when they should be worn or how they should be safely placed on people's feet to avoid shearing people's skin.
● Following our feedback, the registered manager arranged a meeting with the district nurse team, with the aim of improving communication and ensuring the home's care staff were given guidance needed and this was recorded in care plans.

Staff support: induction, training, skills and experience
● Staff received an induction and training and felt they had the skills they needed to care for and support people in a safe way. Some staff and relatives felt more in-depth dementia care training and management of behaviours that could challenge would benefit new staff to help them develop their skills. One staff member told us, "I feel a bit stressed when I work with new staff as they don't have the skills or experience needed to manage some of the more extreme behaviours people living with dementia can have at times." One relative commented, "The newer staff don't have a chance in managing my family member's challenging behaviours, they need a bit more training in that area, the more experienced long-term staff have the skills needed."
● Following learning from recent incidents, the registered manager told us they had identified the need for further staff training, including catheter care awareness and this was due to take place during November 2019.
● Staff were offered regular supervision meetings with managers, to monitor their performance and provide them with an opportunity to discuss their development. The registered manager told us they were aware staff's competency assessments, such as those in their moving and handling skills, had lapsed and assured us these were to be scheduled.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had a pre-assessment before moving to live at the home. These assessments were used to

formulate care plans for staff to follow.

● During people's initial assessment they were given the opportunity to share information with the provider and staff to ensure there was no discrimination, including in relation to protected characteristics under the Equality Act (2010).

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

● The home was purpose built and adapted to meet people's needs, such as hand-rails along corridors. People could access a secure garden area.

● People were supported to personalise their bedrooms as much as they wished to.

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 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, equality and diversity

● There was not always a caring culture due to the management and lack of accountability for when improvements were needed. For example, staff told us they had raised their concerns over past months with managers about the allocation of only one staff member to 'Abbey household'. One staff member told us, "I do my best, but I have to be task focused because I'm on my own." The staff member politely and gently told one person they had to 'go and wait'. This was because they had to give people their medicines, then start to support people to wash and dress, then get people's breakfasts. This meant staff could not always be as caring on an individual basis as they wished to be.

●The registered manager told us they expected duty managers to offer care support, when needed, but care staff told us this did not happen. During both a local authority visit in October 2019 and our inspection visit, duty managers were not seen to support on 'households' and staff confirmed they had not been asked if help was needed.

● People described staff as kind and caring, but told us staff were "too busy". One person told us, "I am so lonely here. The staff are kind but just don't have time to chat. What I'd really love is to just watch my TV quiz show with a staff member and have a laugh together. That would make my day."

● Overall, relatives felt staff showed a caring approach toward their family member. One relative told us, "The care staff have my family member's best interests at heart, they seem kind." Another relative said, "The staff seem to have the right approach." However, another relative told us, "I don't feel my family member is always respected by staff because they often have to wait for support."

● During our inspection visit, when people wished to engage with staff, staff were not frequently available to provide one to one interaction. One staff member told us, "Some people want to chat with us, but we can't often do that, there's not time."

Respecting and promoting people's privacy, dignity and independence

● Staff promoted people's independence when they could and gave examples of how they encouraged people to maintain their skills. One staff member told us, "Most people living here need help with things, but I encourage people to do things for themselves when they can."

● People's privacy and dignity was respected. Staff consistently knocked on people's bedroom door before entering.

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

● Care staff wanted to do their best and were committed to improving the quality of care. Staff wanted people to be fully involved, but overall felt this was difficult as they had become more task led. One staff

member told us, "This is not just a job to me, I want to really care for people and give them a good day, but if we don't have enough staff we can't do that. I've worked here for many years and people's needs are, overall, now much higher and I don't feel that is recognised by management."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

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

● People had individual electronic care plans. However, these did not consistently provide staff with the right information to provide individualised care. Some care plans provided an accurate and clear account of what was required. However, other records reviewed, showed gaps in information about people's individual needs.

● The registered manager told us no one living at the home had epilepsy. However, one person's care notes stated they had epilepsy and during a previous seizure had required emergency treatment. There was no care or risk management plan about this person's health condition. Following our feedback, the registered manager took immediate action to implement a risk management plan. An alert was also shared by the provider in their other homes to ensure people with specific health conditions had associated risk management plans.

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

● Planned activities were displayed in both written and pictorial format. People and their relatives gave us positive feedback about those that took place. One person said, "I've been on trips out and really enjoyed myself." A relative said, "Staff try to get my family member involved in things, like a sing-along, which they enjoy." However, whilst feedback about activities was positive, people and relatives felt more were needed. For example, one person told us, "There are days when nothing happens."

● During our inspection visit, minimal opportunities for stimulation were offered to people either as a group or individually. People cared for in their bedrooms were at risk of social isolation. One staff member told us the activities staff member had reported "no one wanted to do anything". However, when another staff member had time between tasks to offer a game of dominoes to people, they joined in. Another person who spent time in their bedroom told us, "I just want a chat with staff."

● There was one 'lifestyle coach' who offered activities across four days and the provider was recruiting for a second 'lifestyle coach'. The registered manager told us care staff offered activities when designated activities staff were not working. However, we found care staff had limited opportunities to provide stimulation for people.

Meetings 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.

● There was signage around the home. People had personalised display boxes outside their bedroom door

to help them orientate to their own bedroom. Bathrooms had signage to help people find toilets. However, where one bathroom was locked due to a safety issue, we observed one person living with dementia repeatedly trying to open the door. The signage had not been covered which meant the person was confused when they could not enter the bathroom. We informed the registered manager about this who assured us the signage would be covered.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy, and this was displayed. Complaints had been received and these had been investigated and the provider and registered manager aimed to use these to improve the quality of the service. However, we received mixed feedback from people and relatives about whether the registered manager and provider responded to their concerns with a willingness to learn and improve the service. For example, one relative told us following them raising an issue, improvement had made but not sustained and the same issue was reoccurring.

● People and relatives told us about their current, and past, concerns about the call bell system not always working and the impact this had on the responsiveness of staff. This issue is further reported on in safe and well led.

● People and relatives had the opportunity to attend 'resident or relative meetings' if they wished to. One relative told us, "The relative meetings give me a chance to give feedback, though there are more staff at them than relatives."

End of life care and support

● The home did not specialise in end of life care. However, the provider aimed to support people's wishes to remain at the home for end of life care whenever possible and in line with people's wishes.

● People and their relatives were given opportunities to share information about their preferences for end of life care. Advance planning took account of people's wishes to meet their individual cultural and religious preferences.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection this key question was rated Outstanding. At this inspection this key question has deteriorated to Requires Improvement. This meant the service was not always well managed and well led. Leaders and the culture they created did not always promote high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● Care staff told us the management team did not always support them when needed or seek and respond to feedback with an openness, which was inclusive and empowering. For example, one staff member told us, "I was very concerned about [Name]'s health, I immediately asked a duty manager for support, but there was no sense of urgency. They did not give any support until I made a second request and repeated the urgency."

● We received feedback before and during our inspection visit that raised concerns. Staff comments included, "Staff morale is poor. There is not enough flexibility in the staff team to cover absences and holidays," and, "The manager does not like to use agency, so staff are pulled from other tasks to do something and that then affects another area, such as the cleaning." Another staff member told us, "Investment in the infrastructure here needs improving, for example we don't always have working hand-held devices which we need."

● The provider had systems of auditing the safety and quality of the service, and the registered manager, duty managers and the provider's quality assurance team undertook regular audits. However, these were not always effective in identifying where improvements were needed.

● Quality assurance checks on care records had not always identified gaps in important information. For example, where people had specific needs related to a health issue, a medical in-dwelling device or behaviours that could challenge staff, care or risk management plans had not always been written.

● Infection prevention and control audits had not identified potential risks of cross infection when staff did not use personal protective equipment (aprons) to prepare breakfasts after supporting people with personal care. Checks on cleanliness had not identified deep cleans did not always take place as intended.

● Medication audits were completed and had identified issues to be addressed. For example, on an audit dated 9 October 2019, one person's paracetamol in-stock did not correspond to the expected number. There was no record of actions taken to address this.

● Where actions on medicine checks had been noted, there was not always a record to confirm the required checks had been actioned. For example, one entry stated "Possibly given by night staff, not taken off the system, speak to staff."

● One relative shared their concerns with us about the quality of recording and the accuracy of what staff had written. When using the provider's 'Relative's Gateway' they gave us an example of care record entry that was incorrect. The relative expressed concerns because this was not the first inaccurate entry they had identified. They felt staff were pressured to record more positive outcomes for their family member rather than accurate details. When we discussed accurate record keeping with the registered manager, they told us a meeting and training session had been arranged for staff to give guidance on record keeping.

● The provider's service user dependency level calculations and management systems did not always

ensure staffing levels on 'households' were sufficient to safely meet the needs of people in a person-centred way.

● Provider level oversight had not always ensured actions to mitigate identified risks were carried out in a timely way. For example, where people had sustained injuries, information and analysis had not always been used in a timely way to ensure risks were mitigated to reduce risks of reoccurrence.

● People, relatives and staff told us about 'ongoing problems' with the call bell system not triggering a 'beep' on staff's hand-held devices. Whilst engineer call-outs had taken place to address identified issues, we were told this was a recurrent problem. This posed potential safety risks to people if staff could not respond to alerts being triggered or requests for support. There was no evidence of contingency plans having been put in to place by the provider for when the hand-held devices were not working as they should.

The above concerns constituted breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17, Good Governance.

The day after our inspection visit, the registered manager told us the problem with the hand-held devices had been identified by their external company engineers, however, they were unable to rectify the issues. The provider acted on this and on 17 October 2019, the registered manager told us staff had enough working and spare devices to maintain people's safety and quality of the service whilst a full review of the system was undertaken.

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

● The registered manager told us they operated an 'open door' policy, so that relatives, people and staff could visit them at any time. Relatives told us the registered manager was approachable.

● The registered manager understood their regulatory responsibilities. For example, they ensured that the rating from the last Care Quality Commission (CQC) inspection was prominently displayed, there were systems in place to notify CQC of serious incidents at the home.

Working in partnership with others

● The service had links with external services. These included electronic links to best practice guidance, commissioners of services, nurses and health professionals. These partnerships demonstrated the provider sought best practice to provide people with good quality care and support. However, our findings showed information was not always used to achieve the provider's aim.

● The registered manager actively sought opportunities to work with other bodies to increase people's enjoyment in life. For example, local schools and community centres, religious organisations and charities to increase people's opportunities for social interaction. However, feedback from people, relatives and care staff showed improvement was needed to ensure people had enough opportunity to enjoy each day.

Continuous learning and improving care

● The registered manager recognised the importance of continuous learning. They attended the provider's 'managers group meetings' where learning was shared.

● The registered manager had recognised their need to increase their knowledge in skin care and how to minimise risks of skin damage and had signed up to join a local hospital forum tissue viability group.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person. The provider had failed to ensure they always gained the authority required before they administered medicines to service users in a covert (disguised in food or drink) way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not consistently ensure care and treatment was provided in a safe way for service users. Risks had not always been assessed and risks had not always been mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes did not always effectively assess, monitor or mitigate risks related to the health, safety and welfare of the service users who may be at risk from the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not always ensure there were sufficient numbers of suitably qualified,

competent, skilled and experienced persons deployed to meet service users needs.