The Paddocks Care Home Ltd

The Paddocks Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Paddocks is a residential care home registered to provide personal care for up to 100 older people, some of whom may be living with dementia. There were 63 people using the service when we inspected. The Paddocks is split into three units, two of which are residential and one which was for people living with dementia. One of the residential units was in the process of being refurbished and had minimal occupancy. The dementia unit was a totally separate building and operated somewhat independently with its own staff.

People's experience of using this service and what we found
Poor communication and recording systems placed people at risk. Audits did not identify patterns and trends relating to risk. This meant staff did not take prompt action to mitigate risk and ensure they met people's individual care needs.

The environment posed some health and safety hazards, some of which had been identified by the service but not acted upon. Systems designed to give oversight of various aspects of the service were not robust. This was of particular concern in the main kitchen. This was not clean even though regular cleaning schedules had been signed as being completed and cleaning practices regularly audited. Domestic cleaning staff understood infection control procedures but poor hygiene practices in the kitchen placed people at risk.

The poor recording, ineffective auditing and lack of co-ordinated systems to identify and meet people's care needs meant that we had significant concerns about the leadership and governance of the service.

Following our inspection we required the provider to take action on the most serious issues we found, relating to the safety and quality of the service. The provider did this and continued to keep us updated about their progress. Due to this prompt and comprehensive response, and the open and honest dialogue the provider had with us, we did not take any urgent enforcement action.

Staff were recruited safely and staffing levels were appropriate on the days of our inspection. However, some people shared negative feedback about sometimes having to wait an excessively long time for personal care. Medicines were well managed, and staff understood their responsibility to safeguard people from abuse and effective systems were in place.

Staff were trained and supported to carry out their roles. Staff managed people's healthcare needs well but poor information systems meant some people did not always get the care they needed. People's dietary needs were not always well managed. Feedback about the food was not positive and the service did not always identify and respond quickly to people's increasing or decreasing weight.

People consented to their care and support, although some records relating to consent required reviewing. People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were caring, patient and kind. They went the extra mile and feedback about the staff was very positive. They created a warm and homely atmosphere within the service. However, constant call bells, set off by motion sensors on the unit where people were living with dementia, impacted negatively on this and caused people living there some distress.

Poor recording systems made it impossible for staff to demonstrate they provided person centred care. Repositioning, food and fluid charts were not always completed and we were not assured people were getting all the care they required.

The service provided appropriate activities for people on the residential wings and supported them to follow their hobbies and interests. People living with dementia were not so well catered for and most were under occupied much of the time.

There was an effective complaints policy and procedure in place. People received good end of life care and their wishes regarding the end of their life were recorded.

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

Rating at last inspection
The last rating for this service was Good (published 22 September 2017.)

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

Enforcement
We have identified breaches in relation to safety, the cleanliness of the environment, person centred care and leadership at this inspection. Please see the action we have told the provider to take at the end of this report.

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

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

The Paddocks Care Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors on an out of hours visit on 27 February, two inspectors and two Experts by Experience on 28 February and by one inspector on 2 March 2020. 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
The Paddocks is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service including notifications of incidents and accidents which they are required to send us by law. The provider also completed a Provider Information Return (PIR). This is something providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We spoke with colleagues from the local authority safeguarding and quality monitoring teams to get feedback about the service. We used all of this information to plan our inspection.

During the inspection
We spoke with 15 people who used the service and five relatives about their experience of the care provided. We spoke with 16 members of care staff, four of whom were senior care staff. We also spoke with one member of the domestic staff, the kitchen manager, the maintenance manager, the deputy manager, registered manager and operations manager.
We reviewed a range of records. This included five people's care records and seven medication administration records. We looked at one staff file in relation to recruitment and other records relating to staff training and supervision. We also viewed records relating to the quality and safety of the service.

After the inspection
We continued to seek urgent clarification from the provider about the significant concerns identified during the inspection. The provider sent us confirmation in the days following the inspection that some works to make the service safer had been arranged and that others had been completed. We required the provider to keep us updated with a weekly action plan documenting all actions they were taking to address the concerns we had regarding the safety and governance of the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

●People had individual risk assessments in their care plans. These related to a variety of issues including falls, choking and pressure care. However, the service had not identified some significant risks or taken action to reduce them.

● One care plan documented that a person had been discharged from hospital with a serious injury in December 2019. This information had been overlooked by staff and was not noted in any part of the person's care plan. The service had not considered any additional risks this posed related to this person's moving and handling needs. We noted that this person had had seven falls since this injury but had not been referred to the falls team for further advice and guidance. Records documented actions such as 'To check [person] regularly and make sure [they have] their bell with [them].'

● Another person's care plan documented a similar number of falls. Staff had not referred them promptly to the falls team and had only done so at the suggestion of another healthcare professional. The person had sustained wounds and bruising in recent falls.

● Staff assessed people's risks of developing a pressure ulcer but measures to reduce and manage this risk were not clearly documented and staff were confused. Repositioning charts to document how staff had changed a person's position to reduce pressure on one particular part of their body, were not completed as required. Staff contradicted each other when we asked how often a person should be repositioned. Two people had pressure ulcers at the time of our inspection and records for one of these people were incomplete. We were not assured that people were receiving the correct care to ensure their pressure ulcer improved.

●The staff had assessed one person to be at a medium risk of choking. Their care plan documented no further action to reduce the risk, such as observing them eat their meals for example. We observed that another person had left their meal uneaten and staff did not clear this away promptly. We asked if any other person might be at risk if they tried to eat this food. Staff confirmed that one person would and stated," But we would stop [them] before [they] got there because [they] are slow." This was not an effective strategy as we observed times when no staff were around as they were busy helping other people.

●People living with dementia were also found to be at potential risk from items such as creams, lotions, cleaning products and razors. Risk assessments documented that these should be stored safely but we found they were not securely stored in people's rooms and people had free access to them.

● We also identified some risks associated with the environment. An inspection hatch cover in a corridor posed a trip hazard. Wheelchairs were stored in corridors and could have posed a trip hazard or have impeded people's exit from the building in an emergency. An ironing board was blocking a fire exit. Wheelchairs and the ironing board were removed during our inspection visit and the provider confirmed they would find more suitable storage for these items. We noted two uncovered radiators, one of which was

very hot to the touch. This posed a risk of scalding should a person fall against it and be unable to move.

● Health and safety monitoring of the environment and equipment was not as robust as it should have been. Although routine checks had taken place regularly, actions had not always taken place where issues had been identified. For example, the monthly check of window restrictors carried out on 31 January 2020 recorded that the vast majority were not shutting properly. This left people exposed to a potential draft and did not ensure that the building was entirely secure.

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

Preventing and controlling infection

●Some open foodstuffs in the main kitchen had not been labelled with the date they were open and some were not stored correctly. This could have made them unsafe to use.

●The main kitchen, which supplied meals to two units, was not clean. Equipment was visibly dirty with a build-up of dirt and grease. A deep fat fryer was not being used as it was faulty but still contained oil and was not clean. There was no notice on it to warn people that it was faulty, although the operations manager had told staff not to use it and they were aware.

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

●Following our inspection the provider arranged for the kitchen to have a deep clean and then for external contractors to come in and do an additional clean of all areas.

●The rest of the service was clean, and the domestic staff demonstrated an understanding of infection control procedures and received training. Staff had access to the equipment they needed to reduce the risk and spread of infection. Where people had health conditions which meant there needed to be additional infection control measures in place, staff were very knowledgeable about this.

Systems and processes to safeguard people from the risk of abuse

●People told us they felt safe. Staff received safeguarding training and were able to tell us how they would recognise and report any safeguarding concerns The registered manager had made safeguarding referrals when needed and was aware of their responsibility to take prompt action.

●One person told us about a safeguarding incident where another person who used the service came into their room and attempted to harm them. We saw that this incident had been well managed at the time, reported to CQC and to the local authority safeguarding team and actions put in place to reduce future risks.

●There had been three thefts of people's property identified in recent months. On the day of our inspection another person alleged that some personal property had gone missing. The staff reacted promptly to investigate. Where appropriate, matters had been referred to the police. The entrances to the various buildings were all secure, with keypad entry. However, some people's ground floor bedroom windows were seen to be open which could have exposed people to an additional risk.

Staffing and recruitment

●The provider recruited staff safely, carrying out appropriate pre-employment checks.

●We received mixed feedback about staffing levels on both the residential units and the unit for people living with dementia. Some people were very happy with the staffing levels. One person commented, "If I need help in the night, they usually come within five minutes." A relative said, "They do use agency staff sometimes but mostly I see the same faces which is good because they know me, and I've got to know

them."

●However, we also received comments about how staffing levels impacted negatively on people's care and dignity. One person said, "There are times when they are clearly under-staffed, mornings are often bad, and I'll know because they'll ask me if I can change my [incontinence] pad later……What can I say? I have to say yes don't I?" Another commented, ""If I get up about 06.30 [my care] is done quite promptly, but if I leave it much later I have to take my turn." A third person commented, "Generally if I press the bell at night they come quite quickly but more than once I couldn't wait and so wet the bed which is very distressing."

●When we carried out a visit out of hours, we noted that appropriate levels of staff were on duty on all units. Staff were seen to carry out their roles calmly and effectively. Staff told us that they felt there were enough of them, although some commented that in recent months it had been difficult at times.

●The service used agency staff, but this had reduced recently, and more permanent staff had been employed. Agency staff we spoke with told us that they had received a brief induction and felt supported by permanent staff colleagues.

Learning lessons when things go wrong

● Where any incidents or accidents occurred, these were reported appropriately. However, we were not assured that actions always followed to review incidents to pick up any patterns or trends and then take action to reduce any risks.

Using medicines safely

●People received their medicines, including time sensitive medicines, as prescribed.

●Medicines were stored appropriately, and effective stock control systems were in place. Staff received medicines training and their competence to administer medicines was checked three times a year by a competent person.

●Medicines which were given on an 'as required' basis, had clear protocols in place to guide staff. However, some 'homely remedies' such as paracetamol and medicines for constipation, had not all been assessed and signed off by a GP as safe to take with people's other medicines.

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 best 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.

● People's capacity to consent to care and treatment had been individually assessed and reviewed. Some records relating to people's capacity to consent were confused. One person had signed to say they consented to some aspects of their care, but their initial assessment had been signed by a relative. The record stated that it had been discussed with the relative because the person lacked capacity but there was no assessment of this.
●We discussed this concern with the registered manager and operations manager. They were aware that some MCA records needed reviewing and clarifying and had already set aside time to do this.
●Staff received training in the MCA and understood its basic principles. Staff were seen to ask people's permission before carrying out any caring tasks. One person told us, "They will knock and ask if they can come into my room. If I ask them to leave, they will….They explain things before carrying out care and if I ask them to stop, they do."
●Where people had a DoLS in place, this was kept under review and restrictions used were the least restrictive measures possible. The registered manager, and staff, understood the process of making an application and knew the implications of depriving a person of their liberty.

Adapting service, design, decoration to meet people's needs
●The unit where people were living with dementia had a secure garden area for people to use. The building was also secure and keypad entries to all stairways meant people were able to walk throughout the service without coming to any harm.
●However, throughout our inspection visits, members of the inspection team noted the very frequent call bells on the unit where people were living with dementia. This was partly due to the presence of sensor

alarms at the threshold of each person's room and at all fire exits. People who regularly walked around the service with purpose, set these alarms off frequently. This had the effect of taking up staff time to come and investigate each alarm and reset it and meant the environment was not calm. The noise at some points in the day was overwhelming and could be seen to cause confusion to some people.

●The residential units were in the older part of the service. There were some sloping floors which, although clearly signed, were not the easiest surface for people with mobility problems to negotiate. Part of this side of the service had recently been beautifully refurbished but was not yet fully occupied. A large living and dining area afforded additional private space for people to chat with visitors.

●Some areas of the service were not very warm. People who used the service and staff told us that the underfloor heating and some radiators were not working correctly. However, they had been provided with additional portable radiators and blankets and the matter was being investigated.

●The service was homely, and people's rooms reflected their personality and taste. There were pictures and photos throughout the service to help people navigate their way around independently. In the unit where people were living with dementia there were sensory puzzles on the walls to engage people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●People received an assessment of their needs before they moved in to the service. This was designed to make sure the service could meet these needs and to provide an initial framework for people's care plans.

●Assessments included input from relevant family members and professionals, where appropriate, to help provide a holistic picture of people's needs.

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

●There was mixed feedback about the food. Two people commented very positively, with one stating, "The food's excellent. Two or three choices."

●However, most feedback was more negative. People commented on the portion sizes, which some found too big and overwhelming and on the lack of fresh fruit and vegetables. One person said, "We don't seem to get offered much fresh fruit so a friend brings things for me." Another commented, "It's not home cooked, it's all pre-prepared microwave [food] and they put way too much on my plate. I don't even want to start to tackle a full plate of food…..More than anything I would love some fresh fruit – some melon, or grapes or an apple. Is there a shortage?"

●The service used pre-prepared frozen meals which were heated up in the kitchens. We saw people were able to have alternatives to this but also noted that, in one case, a person was promised a particular alternative, waited a long time and then were told it was not available. This resulted in them eating very little.

●The kitchen staff had a good understanding of people's specific dietary needs and requirements. Where people needed specific diets, such as fortified or pureed food, this was provided but we saw no finger foods being given to people. Finger foods are more manageable for people with poor co-ordination or whose dementia makes it difficult for them to manage cutlery. We observed one person living with dementia struggle to eat their soup and spilling it all over themselves.

●People's risk of gaining or losing too much weight was assessed using the Malnutrition Universal Screening Tool. However, this was not always carried out accurately and actions did not always follow. For example, one person's care records indicated that they had gained over 20kg since their admission to the service in March 2018. This meant they were not a healthy weight but records did not document what action was taken, if any, to support them with their diet. They also had an unexplained and significant weight loss in recent weeks, reducing 12 kg in one week and remaining at the lower weight in subsequent weeks. This was not investigated to see if there was any underlying cause. We also found some gaps in this person's weight records, although others were well monitored.

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

●People's needs relating to their diabetes were understood by the staff we spoke with but care plans could be more detailed. Records contained information about how to identify that a person's blood sugars were not under control and advised staff to report to a senior member of staff. There was an emergency box in one staff office with supplies to help manage a person's unstable blood sugars. This was not mentioned in any care records that we saw and was located under a pile of papers.

●Most people's access to healthcare was good and people told us they could see a doctor, dentist or optician if they needed to. Records showed that staff had referred people to GPs promptly when they suspected they were unwell, and any medicines were quickly in place to treat conditions.

●Staff made referrals to specialist services such as dieticians, physiotherapists and dementia intensive support teams. However, these referrals were not always timely, and some records, such as wound care records, were incomplete. This meant we were not assured that people always had the wound care they needed.

●When district nurses had visited to review a person's health condition staff were not always able to find a record of the visit or of the treatment and advice given. The registered manager and operations manager acknowledged this failure when we discussed it with them. In the days following our inspection they told us they had introduced a more transparent system of observing and recording healthcare professionals' visits.

Staff support: induction, training, skills and experience

●Staff were skilled and knowledgeable in their roles. They received a comprehensive induction and completed the Care Certificate, which is a nationally recognised scheme for newly appointed staff. One staff member, new to care, told us how well they had been supported, saying, "I learn something new every day. I did a shadow shift [on one unit] and then two more here. I said 'I need another one' and they were brilliant."

●Staff received ongoing training and support. Staff had supervision sessions and an appraisal system was in place. Staff told us they felt well supported and had the training they needed.

Requires Improvement

Is the service caring?

Our findings

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

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

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

● People told us staff provided their personal care sensitively and in private. One person explained, "Even the least dignified tasks are performed to protect my dignity and privacy as far as possible." However, three people we spoke with had not been supported to have a bath as regularly as they wished. Two of these people were very unhappy about this. One said, "I'm not getting a weekly bath. Once it went five weeks before they could do it…..I really don't know why" A second commented, "I've not had a bath for three weeks – a body wash is not the same."

●People told us staff were kind and caring and praised the patience of the staff. One person said, "Some of the staff are really outstanding. My care here has been exemplary. Almost all are skilled and show both empathy and intelligence." We observed staff treating people with patience, kindness and anticipating their needs. Staff, including new staff, knew people well and were able to tell us about their needs

●We observed a staff member coming very promptly to check that a person living with dementia was ok. This was because their room sensor alarm had been turned off by another staff member whilst we were chatting to the person so it didn't keep going off.

● We observed staff providing support to a person as they walked back to their room with their walking frame. The staff members demonstrated great patience and, when the person became confused, they gently distracted them with a joke and got them back on track. Another person commented how kind and gentle staff are when using the hoist with them as they found it frightening. They said, "They are aware it can hurt me or be uncomfortable and they are very thoughtful. If I tell them it's not right, they'll stop and make adjustments."

●We noted that the care records for one person living with dementia indicated that they had reduced their use of medicines for calming their agitation. This had happened since they had come to live at The Paddocks. The reduction was thought to be due to staff taking time to support them with their anxiety and confusion and focus them on other things.

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

●People, and their relatives where appropriate, were involved in decisions about their care. People met with senior staff and signed their care plans to demonstrate their agreement. One relative explained, "We talk with carers about what's best for [our family member] and between us we agree any changes to [the] care."

●We saw staff listening to people's choices and acting on them during our inspection visit.

● People's records included their preferences relating to their care, including their likes and dislikes. We received some negative feedback about how some specific preferences were not always respected. People

mentioned staff not listening to them regarding the size of the meals, an issue with their room or having their fingernails cut regularly, for example.

Requires Improvement

Is the service responsive?

Our findings

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

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

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

●Care plans and other records were poorly organised. This meant that people's individual care needs were not always clear. Records such as repositioning charts and food and fluid charts were not always completed. Records relating to input and advice from healthcare professionals were very difficult to find. This meant there was a risk that people's needs were not always met.

●Individual sections of the care plans were reviewed each month and a full review of the care plan took place every three months. However, these reviews did not always include new information which might have an impact on people's needs. For example, where one person had had a series of falls, it was recorded that their care plan would be updated to reflect this but this had not happened.

●We noted that the same person had raised an issue about wanting more food at lunchtime and teatime and needing more activities to keep their mind active. The care plan recorded the actions to meet these needs as 'keep [person's] dignity, keep on caring for [person] and keep pain free.' This was a poor response to the person's stated needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●However, despite poor and confusing records, we found that staff were mostly aware of people's individual needs and were doing their best to meet them. Staff knew people well and were able to tell us, in detail, about their needs, preferences and life histories. Care plans included a 'This is Me' document and detailed information about people and their former lives. Plans documented if people preferred to receive their care from male or female staff and this was respected unless the circumstances were exceptional.

●Care plans contained information on how to manage people's distress reactions and anxiety and confusion relating to their dementia. One person's plan documented clearly the kind of behaviour a person might have and listed strategies to help distract the person. It also considered how the person's behaviour could socially isolate them from other residents and listed strategies to minimise this and help them fit in.

Improving care quality in response to complaints or concerns

●There was a complaints policy and procedure in place and people told us they knew how to make a formal complaint if they needed to. The policy was available to people should they wish to consult it and was clearly displayed within the service.

●There had been nine formal complaints in the last 12 months. These had been fully investigated and action had promptly followed to address them in line with the provider's procedure.

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

●People told us they enjoyed the variety of activities and outings the service provided. One person said, "I take part in most things. The activities co-ordinator has artistic abilities to inspire us." Another person praised the regular minibus outings. People were enabled to access their usual hobbies and interests in the local community if they were able to. People attended the local church and went shopping in the town. The service was rooted in its local community, helped by being so well sited in the town centre.

● Local nursery school children visited the service regularly and during our inspection the service was taking part in national bread week. People told us they enjoyed these regular themed events. We also observed some lovely one to one interactions, such as a member of staff folding serviettes with one person.

●However, people who were more able and living on the two residential wings were better catered for in terms of daily occupation. On the wing where people were living with dementia there was less stimulation. Activity staff were on shift and a programme of weekly events such as a film morning and coffee mornings was planned.

●There was a sensory room on the unit but one resident had come to see this as their own space which meant we did not see others using this space. During all three days of the inspection process the same DVD was playing in the upstairs lounge all day and all evening. Staff, who were often very busy carrying out caring tasks and completing records, had not appreciated this.

Meeting people's communication needs

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

●Where people had specific communication needs these were noted in their care plan and understood by staff.

●Information was available in accessible formats for people. The service had access to advocacy services when people needed this additional support.

End of life care and support

●There was a section in people's care plans to document their end of life care wishes. The service had delivered the Six Steps to Success programme which aims to promote a co-ordinated approach to end of life care.

●Staff ensured that when people were nearing the end of their lives, anticipatory medicines were made available promptly. Staff worked in partnership with other local services. This aimed to ensure people's final care needs were anticipated, met and any pain controlled.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We found a lack of effective recording and reporting procedures. Records were not always accurate or updated to reflect the most current information.

● Information systems were not fit for purpose. Information was recorded in multiple places, which caused confusion. For example, one person had had eight falls since the start of December 2019. These were recorded in four different places and only by reviewing all four places could staff have a picture of the person's increased falls risk. This lack of oversight meant the person had not been referred to the falls team, despite some falls being on consecutive days and one causing a serious injury which staff overlooked.

● A second referral confirmation could not be located. Staff were unclear when or even if the person had been referred to the falls team. A staff member said, "It could be anywhere". Staff offices were full of paperwork, much of it waiting to be filed, and admin tasks were seen to take up a great deal of staff time. Another staff member commented, "Information gets lost on a unit like this where it's so busy and there is so much risk……. It's unmanageable but we do our best."

● Staff told us that there had been a recent change to the daily observation charts including repositioning records. This had not been successfully implemented and staff were unclear about how and where to record some key information. The provider had listened to staff concerns on this and was in the process of changing the system again. In the interim, this poor recording continued to place people at risk.

● Systems to assess and mitigate risk were not robust. Environmental risks such as uneven flooring, poorly fitting windows, a blocked fire exit and unsafe storage of items such as creams and razors had not been identified and action taken to reduce them.

● The health and safety audit had identified some of the issues we found but actions were not always noted. This was partly a records issue and partly because actions had not been taken. A fire risk in the roof space in one building had been identified over 18 months ago. We had been in communication with the service since that time to find out when remedial action would be taken. Following this inspection, the provider confirmed a date for the works to start.

● Audits of food safety and hygiene practices in the kitchen were not fit for purpose as they did not identify and address the significant issues we found. The kitchen audit was regularly carried out by senior kitchen staff but no other more senior staff had oversight of this and so were not aware that it was not accurate. The system designed to identify risk and ensure safe practice did not protect people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The experienced registered manager understood their legal duty to inform CQC of relevant incidents and had done so when required. Following our inspection, the provider took immediate action to address our most serious concerns and to mitigate risk. They were honest and open about the failures of their systems and processes and began to devise new ways of working. Staff told us the management team asked for their input and listened to their ideas to help drive improvement. Staff told us that this was their usual practice.
● People who used the service, staff, relatives and professionals were asked for feedback about the service in an annual questionnaire. There was no recent data from these as they had only just been sent out. We reviewed the last residents' survey and saw that very little constructive comments had been made, although one person requested more home cooked food. The service had since decided to swap to pre-prepared frozen meals which they buy in bulk.
●The service held three residents and relatives meeting a year which were well attended. These gave people a chance to be part of decisions about issues such as the new décor, new equipment and activities, for example.
●The registered manager held a brief meeting each day with heads of department and senior staff to check the priorities for the day. Staff meetings took place with senior staff every two months and with care staff every two to three months. Records showed that these were not very well attended (with only eight staff attending the last one on 14 February 2020.) We noted that some of the concerns we identified during the inspection had been raised by staff at the meeting including duplication of paperwork and confusion about records,

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their duty of candour and knew which issues needed to be shared. This included sharing key information with people, or their representatives, apologising for any shortfalls and assuring people how lessons had been learned.

Working in partnership with others
●. Professional health and social care teams worked with staff to help them to implement their advice and guidance. Poor communication systems hampered the flow of important information relating to people's care and support.
●. The provider ensured a management structure was in place above the registered manager which was designed to advise, monitor and support. Although clearly supportive, this senior management team needed to improve their oversight of the service as a whole.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received care and treatment which met their needs. Regulation 9 (1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure they assessed and mitigated risks to people's health and safety. Regulation 12 (1) (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises were clean. Regulation 15 (1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they operated effective systems to assess, monitor and mitigate risks and ensure the quality and safety of the services provided. They also failed to maintain an accurate record of people's care and treatment needs.Regulation (1) (2) (a), (b) and (c).