The Dr French Memorial Home Limited

Dr French Memorial Home Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The Doctor French Memorial Home Ltd is a residential care home providing accommodation and personal care for up to 27 people. By the second day of the inspection there were 23 people living at the service.

The service supports mainly older people, with mental health or physical health needs.

People's experience of using this service and what we found
Feedback from relatives and people on the care provided at Dr French Memorial Home Ltd was positive such as kind and caring staff, clean and well-maintained environment and a responsive management team. However, we found significant concerns throughout the inspection which impacted on safety and quality of care and people's well-being.

We were concerned that despite quality issues being raised at the last two inspections, remedial action in key areas to ensure people's safety had not been implemented. We remained concerned at the lack of care planning documentation including risk assessments. We also found continued concerns with supervision, lack of effective audits and medicines management.

At the last inspection we found people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We found the provider and registered manager did not have a comprehensive understanding of their obligations under the Mental Capacity Act 2005. We found that this remained the case at this inspection.

We found the provider and registered manager did not provide effective leadership, to support the staff to provide good quality care to all the people living at the service.

Although staff understood how to safeguard people from abuse. The registered manager could not show they had taken all remedial action to safeguard people from abuse. The registered manager and provider had not understood their obligations to notify CQC of all significant events.

There were insufficient records to evidence that extremely vulnerable people were receiving adequate food and hydration.

For people who had lived at the service for some time, long standing staff worked hard to provide person-centred care. But lack of person-centred care planning, and the lack of information in care plans meant the information was not there for new staff to follow. Also person centred information related to new people entering the service was not captured on care plans.

We found issues with recruitment of staff as not all checks had taken place in line with legal requirements prior to staff starting work. This meant the provider had not taken all reasonable steps to ensure staff were

safe to work with vulnerable people. This was resolved by the time of writing this report.

Whilst we found the home was odour free and clean, we found issues with infection control and staff were not always using personal protection equipment, including masks effectively.

Rating at last inspection and update
At the last inspection we rated this service requires improvement (the final supplementary report was published on 29 October 2021).

At that inspection we identified significant concerns regarding the governance of the service and safe care and treatment of people. This resulted in two Warning Notices being issued against the provider and registered manager related to safe care and treatment, and good governance of the service.

We also found breaches of the regulations in relation to person centred care and the need for consent.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dr French Memorial Home Limited on our website at www.cqc.org.uk

Why we inspected
We undertook this inspection on 18 February and 1 March 2022 to check the provider had followed their action plan, and to confirm they now met legal requirements related to the Warning Notices and the breaches of the regulations.

We carried out a full comprehensive inspection covering all five domains, safe, effective, caring, responsive and well-led.

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

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

We have identified four repeat breaches in relation to safe care and treatment, person centred care, consent and governance of the service at this inspection. We have identified new breaches of the regulations around meeting nutritional and hydration needs, safeguarding and notifying CQC of other events. We have also made a recommendation in relation to the way the staff training is recorded.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Follow up
For services in special measures we usually return to inspect within six months. In the coming months, we plan to meet with the provider and registered manager, and work with the local authority and local health professionals to monitor actions for improvement.
We will continue to monitor information we receive about the service until we return to visit as per our inspection programme. If we receive any concerning information, 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Dr French Memorial Home Limited

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.

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

Inspection team
The inspection was carried out by two inspectors, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience visited the service to speak with people living there, and then spoke to people's relatives by phone to request feedback. These calls took place in the week after the inspection visit. Two inspectors carried out a second inspection day at the service and spoke with two additional relatives.

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

The service had 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
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We also sought feedback from the local authority and professionals who work with the service. In addition, we reviewed recent communications and statutory notifications received by CQC from the service. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager, the assistant manager, four care staff, the chef and the two members of the board of trustees who provide leadership to the registered manager. We also spoke with six people who lived at the service and one family member who was visiting.

We looked at nine care records. We looked at various documents relating to the management of the service which included medicine administration records, three staff recruitment records and training and supervision records for the team. We looked at staffing rotas, infection control records, accident and incident logs, behaviour logs, and quality assurance records.

After the inspection we spoke to four relatives and obtained more information from the registered manager and provider regarding staff meetings, audits, supervisions, training, infection control documents and policies. We also obtained feedback from six health and social care professionals working with 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 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
At our last two inspections the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• At this inspection we found there were insufficient risk assessments in place to identify risks and provide staff with guidance on how to manage them. Where risk assessments were on record these were incomplete and outdated. Risk assessments were not reviewed regularly to reflect people's current care needs.
• For example, one person had epilepsy, but there was no risk assessment to guide staff in how to manage this. Staff had not been trained in how to manage seizures.
•We found another person at risk of choking without a risk assessment by speech and language therapists to advise staff on supporting them safely. This person also had dementia and was at risk of falls, but there were no risk assessments in place.
• We found other people without risk assessments related to choking skin integrity, and diabetes. Staff had not been trained in the management of diabetes.
● The registered manager did not appear to have an effective understanding of how the service could support people with mental health needs, particularly those who may show signs of distress and anxiety.
● For example, when people behaved in ways that could indicate distress or anxiety, staff completed 'behaviour charts' for some people when incidents occurred, but they were not reviewed to see if there were patterns to help identify possible triggers or possible solutions. This meant that risk assessments and care plans were not in place to provide guidance to staff and help people avoid distress and anxiety.
● We were also concerned that the service did not have a clear policy to guide staff in managing head injuries. For example, staff did not always seek medical advice when people suffered a head injury. Best practice would be for a health professional to give guidance to staff, to evaluate if the person needed immediate evaluation by ambulance staff or to be monitored on a regular basis. The lack of a policy meant there was no consistent approach by staff to manage potentially life threatening injuries.
● The service did not have a 'grab bag' to ensure that key information regarding people, including personal emergency evacuation plans (PEEPS), was available in the event of an emergency evacuation of the building.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a

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

Using medicines safely
At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• At the last inspection we were concerned that the service was not following best practice guidance in the giving of medicines covertly. Covert administration is when medicines are administered in a disguised format. This remained a concern at this inspection. One person living at the service was being given medicines covertly without the appropriate documentation showing key health professionals had been involved in the process. When a person is deemed to lack mental capacity, but it is determined to be in their 'best interest' to have medicines given to them against their will, best practice is that the prescriber and pharmacist are involved in the decision making process. They ensure that the medicine is necessary and give advice on the safest method to give the medicine. This was raised as a concern at the last inspection, and this remained the case at this inspection.
• The service had a policy on the giving of medicines covertly, but were not following their own guidance which stated, 'Any decisions and actions must be documented in the service user's care plan and reviewed regularly'
• Following the inspection in August 2021, a community pharmacist had carried out an audit in November 2021 and set out actions for improvements to be implemented by 15 December 2021. These included advice for 'as needed' PRN protocols to be set out so staff understood when to give these medicines. The pharmacist also advised care home staff to change the method for the giving of a specific medicine as its effectiveness was reduced by being given in porridge, due to the presence of milk. We found the care staff continued to give this medicine in the same way, over two months later. PRN protocols were still not in place for people.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service had suitable arrangements for ordering, receiving, storing and disposing of medicines. Storage temperatures were monitored to make sure medicines would be safe and effective.
• Medicine Administration Records (MARs) were completed appropriately.
• There were medicines competency assessments in place for all but one staff member giving medicines. This was completed by the time of writing the report.
• This issue is discussed further in the Well-led section of the report.

Learning lessons when things go wrong
• We were not confident that the registered manager had effective systems to share information with the staff team when incidents took place. For example, when a person had a seizure, this incident did not prompt the registered manager or provider to set out a care plan or risk assessment to guide staff in how to manage this person's health. We found one person without capacity to safely leave the building absconded on several occasions from the service. The registered manager did not put in place checks to minimise this happening again.

• Since the last inspection, a more effective handover system was in place which meant information on a day to day basis was shared across staff. However, the lack of evidence of remedial action to minimise future harm to people was of concern and showed us that lessons were not always learnt when things went wrong. This is discussed further in the Well-led section of the report.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• We had some concerns regarding the infection control practices at the service. Most staff were seen to wear Personal Protective Equipment (PPE) such as masks, gloves and aprons. However, we repeatedly saw staff and some members of the management team either not wearing masks appropriately or not at all. This was something that was also witnessed by other visiting health and social care professionals. This had been raised at the last two inspections.
• PPE was readily available for staff at the service, although we noted there were not masks available upstairs for staff. This was rectified when drawn to the registered manager's attention.
• Visiting health and social care professionals also noted the lack of soap in one person's room. This was of concern as this person had continence issues.
• We noted that wheelchairs were not wiped between use by people, as they were only cleaned by night staff. The registered manager told us they would set out a system to ensure they were sanitised after use.
• The service was odour free and people told us the service was, "immaculate, very clean." Whilst we saw that an infection control audit had been carried out by the registered manager in October 2021, we were not confident that the management of infection control was effective and was audited with the regularity needed.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• We were not confident that the registered manager fully understood their obligations for safeguarding people from abuse. For example, we found that appropriate preventative action had not been taken when one person who was at times agitated and threatening to others living at the service when distressed This person was seen by the appropriate mental health team after several incidents like this, but there was no risk assessment set out for staff in how to safeguard other people or themselves, and there was no safeguarding referral to the local authority in line with guidance. This person's behaviour had escalated in severity of agitation and threat of violence.

This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• In spite of the issues we found, people spoke with said "I feel safe, and all is good here," and Yes, I do feel safe here." One relative said "Yes, safe from what I've observed."
•Staff were trained in the safeguarding of adults, and understood how to report concerns and the importance of whistleblowing

Staffing and recruitment

• We had some concerns regarding staff recruitment as the service had not ensured a Disclosure and Barring Service (DBS) checks had been completed for two staff prior to them starting work. We saw that historical DBS were on record, but they were not out of date for taking up a new position. This is a requirement to minimise potential harm to vulnerable people.

• We discussed this with the registered manager who was unclear regarding the guidance as they thought DBS certificates dated within three years were acceptable, which is not the case. By the time of the second day of the inspection, updated DBS checks had been received, and the service now had the appropriate guidance in relation to DBS checks. Other documents including references were on staff files.

• We had mixed views as to whether there were enough staff to meet people's needs, or whether there were issues with the deployment of staff. Staffing levels ranged from four to six staff on each shift during the day, and three staff at night.

We saw staff were busy, and people acknowledged that staff tried their best. However, one person told us, "I was late for breakfast today." This person told us that they were up at 7.20am on the first day of the inspection but was not brought down until 10.20 when they were given their first cup of tea. Another person said, "Well the staff are very nice but sometimes I have to wait." However, we saw staff patiently supporting people with their meals, in an unrushed way.

• There was no system for evaluating dependency at the service to inform staffing levels. Family members told us they thought there were enough staff to meet people's needs.

• We were aware that there were some staff working long hours to fill gaps in the rota. We discussed this with the management team, who said they would address this, acknowledging this did not contribute positively to providing safe care to people.

• Lack of a dependency tool is discussed in the Well-led section of the report.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection, this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

People can only be deprived of their liberty so that they can 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

●At our inspections in December 2020 and August 2021, we identified that the service had not set out mental capacity assessments for people and ensured the necessary documentation was in place to ensure people's liberty was safeguarded.
●At the inspection in August 2021, we found the provider had failed to ensure consent, or that appropriate documentation was in place for people who lacked capacity, before carrying out specific care for people. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11 at this inspection.

● We found that the service had not routinely carried out mental capacity assessments for people. This meant that the service could not evidence that they were acting lawfully in relation to the giving of care, or giving of vaccinations for people, who lacked capacity.
● Lack of up to date people's mental capacity assessment meant we could not be confident that people's rights were protected.
● There were instances where mental capacity had been assessed on admission, but this assessment was several years old, so it was unclear if people's current mental capacity had been reviewed. This remained the case at this inspection.

We found no evidence that people had been harmed however, systems were either not in place to ensure that care and treatment must only be provided with the consent of the relevant person. This placed people at risk of harm. This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●In spite of these issues, we found staff understood issues of consent on a day to day basis and had received training in this area.
●The service had applied for DoLS for people who lacked capacity.

Supporting people to eat and drink enough to maintain a balanced diet
● We were concerned the service was not safely managing nutrition and hydration for people who were less able to communicate and were at risk of malnutrition and dehydration.
● For those people potentially at risk, we would expect to have food and fluid charts in place which would give guidance to staff, and allow oversight by management, of people's food and fluid intake. Good nutritio0n and hydration,, along with turning charts is particularly important for good skin integrity for people who are less mobile as people's skin is more fragile as they age.
● We either found erratically completed food and fluid charts, or none in place for people at risk.
● We were not confident that people were being weighed with the regularity required when at risk of malnutrition and, there was no evidence of oversight by management of people's weight.
● This lack of accurate information on people's health and well-being was of concern. ● Visiting health and social care professionals have confirmed that whilst they have not seen evidence of poor care, the lack of record keeping and management oversight, meant they too cannot be confident of good quality care being provided.
● The concerns with lack of guidance for staff regarding people's weight loss was identified at the last inspection, and this remained a concern at this inspection. In fact, as people had aged, these concerns were now more significant.
●At the last inspection we highlighted the need for the kitchen staff to be aware of who needed to have a fortified diet to encourage weight gain. At this inspection we found this information was not available to kitchen staff.

We found no evidence that people had been harmed however, systems were either not in place to ensure that the nutrition and hydration of all service users was met. This placed people at risk of harm. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At the last inspection we found that the food offered did not tally with that on the menu, and the kitchen staff did not have information regarding people's choices. At this inspection, we found the kitchen staff had better information to inform the menus. The kitchen staff now had a list of people on soft diets, which helped with effective food preparation
● People told us, "Yes we are given a choice, the food is good" and "We won't starve here plenty of food." A family member confirmed, "Yes, one thing he is has always told me that the food is good."
● We saw that lunch on both days was pleasantly presented and people who needed support with eating were given this in a respectful and dignified way.

Staff support: induction, training, skills and experience
● We had some concerns regarding the training and supervision of staff.
●Staff received training in most key areas to ensure they were knowledgeable and competent in their role. Training included moving and handling, medicines management, safeguarding and first aid.

●However, the training matrix was not helpful in understanding when retraining was due, and there were gaps which showed 'training in progress' with no date. The training data provided to the inspection team was a matrix related to 2020-2021.

We recommend that the service establish a more effective system to evidence training undertaken and when training is due.

● Staff were not always given all the information to carry out their role. We noted the lack of training for diabetes and epilepsy. We discussed this with the management team who told us they were planning training in these areas at the earliest opportunity.
● We were aware from the poor quality of care records they did not always have adequate information regarding people's needs to support them. But as a number of staff had worked there for some time, they understood people's needs.
● Feedback from people and relatives was good. Feedback from people included, "Well the staff are very nice." One relative told us, "[Person] can be challenging but now they has been there quite a few months they have got used to their needs." Another said, "From what I have seen, they have good continuity of care, they are very good."
● We have raised lack of regular supervision at the last two inspections and found that this was still the case. For example, the registered manager passed us a spreadsheet indicating supervision dates, but we found that these did not always tally with actual supervision carried out.
● We discussed this with the registered manager who told us that the management team had started to undertake more supervisions, but she was aware that staff supervision was not in line with the provider's policy, nor reflected the matrix.
●These concerns are discussed further in the Well-led section of the report.

Assessing people's needs and choices; delivering care in line with guidance standards and the law
● At the last two inspections we noted that there was not a clear system to evaluate and record people's needs at the point of admission which was then translated into a care plan with associated risk assessments. We saw some information was collated at the outset and there were reports from commissioners at the point of admission. At this inspection we found this was still the case.
● Whilst the service had introduced a new electronic system, much of the information was generic and so did not set out clearly people's assessed needs.
● We were aware that the local authority had provided significant support to the service, to assist in this task. But unfortunately, this work had not been taken forward in a meaningful sense.

We found no evidence that people had been harmed however, the provider had failed to evidence that care and treatment were provided in a way that met people's needs, be appropriate and reflected their preferences. This placed people at risk of harm. This was a continued breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff appeared to understand most people's needs and were able to tell us about them. This minimised the risk of harm to people. Care planning is discussed further in the Responsive and Well-Led sections of the report.

Supporting people to live healthier lives, access healthcare services and support; staff providing consistent, effective, timely care within and across organisations:
● We had concerns that appropriate referrals were not always made to ensure people lived healthier lives, as speech and language referrals were not in evidence on care records.

● In other ways the service had a good understanding of when to refer to the district nurse for skin care issues, the GP for medical issues and community services like the optician. One person told us, "I had an eye infection recently and they sorted it out for me." Family members confirmed they were happy with the way the service supported their relatives with health care. Comments included, "They have been really good, they are very on the ball" and "They are very good."

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. Whilst staff were caring, the lack of effective systems meant people were not always well-supported, cared for or always treated with dignity and respect

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

- The lack of effective systems for care planning, risk management and management of the quality of care at the service meant that whilst we were confident staff were kind to people, and they told us this. The service could not overall offer a good caring service.
- Staff received training in equality and diversity and spoke a range of languages. People told us there were no issues with their cultural needs not being met. However, care records lacked detail, so this was hard to evidence. For example, one person liked to cover her hair, and put on her lipstick but this was not recorded in any care plans. However, where people could not communicate themselves, information had been shared and passed on from family to staff members.
- As noted previously in the report, people were exposed to risk by the limited involvement of professionals who could support the service, particularly for those with mental health needs. As a result, we saw records of several instances when people were exposed to angry, agitated behaviours. The registered manager and provider did not advocate for these people in a sufficiently caring way.
- However, on an individual staff level, people told us, "Yes I do (find them caring) and if I need something there are always there" and "Yes I would give them nine out of ten for this." Family members confirmed staff were kind. Comments included, "I find them very friendly and observations from what I see good, the try their best," and "Very much so."
- We saw many examples of kind, caring interactions by staff with people at the service. One carer had to remind a person numerous times why they needed support for a medical condition, but they did this with patience and kindness.
- The COVID-19 pandemic had placed additional burdens on the service to support people to keep contact with their family members. At the height of lockdown, this had been done via virtual contact. In more recent months people's family and friends were able to have face to face meetings in the service. Family members told us they were able to book a visit to see their relative quite easily.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were encouraged to be independent and were treated with respect by staff.
- One person told us that staff, "Respect my likes and dislikes" and "I discussed this with my son when I came here and we are very much on top of this. He told me that he is not worried about that as he is very capable of bringing up any concerns." Family members were positive about their involvement in their care.
- One person told us they had no family members and had not been involved in setting out their care arrangements. Personalisation of care records is discussed further in Responsive section of the report. We

were confident staff certainly asked people their preferences and knew their routines.

● Residents' meetings took place for people to give their views on the food, and people were asked if they were happy with the care staff and more generally to comment on the way the service was run. We noted that people were supported to have an alcoholic drink should they choose to do so, and this was appreciated by people.

● People's personal information was kept secure and staff understood the importance of maintaining secure documents and care records to ensure people's confidentiality was maintained.

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 requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

At our last inspection the provider had failed to evidence that care and treatment were provided in a way that met people's needs, be appropriate and reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9

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

- At the last two inspections we found care plans which were not always completed adequately to identify people's needs. At this inspection, this remained the case.
- On admission there was some information gathered, but we found information from commissioners provided to the service was not usually transferred in detail to the service documents.
- As with the last two inspection, care plans lacked details regarding people's health conditions, needs in relation to personal care, mental health and skin care. We found that the staff, by knowing people's needs were by and large meeting them. One health and social care professional commented. "It looks like a generic care plan and the residents names are just changed."
- We saw that a scant monthly review of people's care took place, however, in the absence of specific care plans, the information was generalised and shed little light on changes to people's care needs.
- The lack of person-centred care plans placed people at risk of harm, especially as there were a number of frail people with complex mobility and health conditions at the service.
- These concerns are addressed further in the Well-Led section of the report.

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.

- As at the last two inspections we found care plans lacked detail regarding people's communication needs.
- This was particularly of concern for people who had memory problems or for whom their first language was not English. These concerns are addressed further in the Well-Led section of the report.

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

● There were some activities taking place at the service, but these were limited. The activities co-ordinator worked part time, and there was no programme to tell people what was on offer or when. Only one person could tell us, "I do art and things, very interesting."

● We discussed this with the management team, and were told that the service planned to invite in additional entertainers, and return to activities which had taken place pre-COVID-19.. As the weather improves, the service would resume outdoor activities and have a spacious garden they can use.

● Documentation related to people's activities was limited and did not show that it was personalised.

● These concerns are addressed further in the Well-Led section of the report.

We found no evidence that people had been harmed however, the provider had failed to evidence that care and treatment were provided in a way that met people's needs, be appropriate and reflected their preferences. This placed people at risk of harm. This was a continued breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● At the last inspection we found at the point of admission, people and their families were asked for their end of life wishes. From our discussion with relatives and people, we were not concerned that people's wishes would not be taken into account.

● However, these discussions were not taking place formally as part of a regular review, so there was limited up to date recorded information regarding people's end of life needs and wishes.

Improving care quality in response to complaints or concerns

● We had no concerns regarding the way the service responded to complaints. Relatives told us the management team were responsive and addressed issues. Most had not had reason to complain.

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 inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership.

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

At our last inspection the provider had failed to ensure good governance of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• We remained concerned that the registered manager and the provider did not provide effective management of the service. Neither the registered manager or the provider appeared to understand all the regulatory requirements related to their roles and their duty to ensure quality of care and documentation at the service, was of a good standard.
• Following the last inspection CQC took enforcement action and issued Warning Notices to set out the severity of the concerns we found. Despite setting out specific issues of concern, neither the provider or registered manager have responded effectively and taken appropriate actions. We have not found improvement to evidence the meeting of the Warning notices.
• We have identified a number of issues in the report relating to: care planning and the assessment of and managing risk; lack of mental capacity assessments and documented 'best interest' meetings;. irregular supervision meetings for staff; lack of effective systems for monitoring very vulnerable people's food and fluid and lack of remedial action to minimise future accidents and incidents. The registered manager and provider did not use a dependency tool to evaluate staffing levels against need to ensure the appropriate staff were on rota at key times of the day.
•At this inspection we also saw that people were not always safeguarded from abuse, and the registered manager and provider did not understand and respond proactively to minimising people's agitation or distress.
•Infection control issues were identified as an issue at this inspection, and despite previous discussions with the registered manager and provider, staff were not always using PPE appropriately.
•Further examples of inadequate management include the failure to act on recommendations made by the community pharmacist; minimal audits undertaken by the registered manager and provider meant that there was little oversight of the quality of the service, and the action plan set out following the last inspection was not progressed to good effect.
• The registered manager and provider failed to ensure that effective systems and processes were

established to assess, monitor, mitigate risk and improve the quality of the service to people.

Working in partnership with others
• We had mixed views about the ability of the service to work with other health and social care professionals. Health professionals worked effectively with the staff at the service to achieve good outcomes. However, we were not confident that all relevant health referrals took place as records appropriately and in a timely way.
• We were aware the local authority had repeatedly offered to support the service and this help was accepted in a limited way, as suggestions to make improvements were not taken forward effectively.
• We have also noted that people were placed at risk of harm by the limited involvement of professionals who could support the service, and people with mental health needs.

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

• Following the first inspection visit the local community matron and their team are providing additional support to the service. The provider is also considering what additional support they can commission to support them and the registered manager in their respective roles.

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.
• We had some concerns regarding the registered manager's understanding of their obligations regarding duty of candour, which involves the need to be open and honest when things went wrong. Whilst family members told us the registered manager was open with them regarding issues that arose, the local authority and CQC were not always kept fully informed of issues of concern.
• We found at least four incidences where CQC should have been notified of 'other incidents', when the police had been called, and had not been.

We found no evidence that people had been harmed however, the service had not notified CQC in line with legal requirements. This placed people at risk of harm. This was a breach of Regulation 18 (Notification of other incidents) of the Registration Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Since the last meeting the service had introduced regular meetings for residents to get their views on how the service was run.
• We could also see that staff meetings took place with regularity since the last inspection.
• The service had also implemented an extended handover document which provided greater information for one group of staff to another.
• Family members told us they felt able to talk with the management team, and in general, were updated on issues regarding health and well-being.
• The service was in the process of setting out a questionnaire to get the views of people using the service, and their relatives.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
• People and their relatives were positive about living at the service. We asked if they would recommend the service to others. Comments included, "Yes, because it is clean and tidy and the food is so good and we are

not cut off from the outside world", "I am very happy with them (staff) and would (recommend it), and it doesn't feel institutionalised."
• Family members confirmed, "I think it's a very caring place, [Person] had been in Dr French and we are happy with it and we have never had any problems. You can't ask for more", "no smells" and "like a home from home."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The provider and registered manager had not notified CQC of four incidences when the police had been called to support staff following an incident, in line with the requirements.

The enforcement action we took:

A Notice of Proposal to cancel the provider's registration was issued following the inspection. Following a representation period by the provider we issued a Notice of Decision to cancel the provider. This means the location is no longer active.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: The provider and registered manager had failed to evidence that care was provided in a way that met people's needs, were appropriate and reflected their preferences.

The enforcement action we took:

A Notice of Proposal to cancel the provider's registration was issued following the inspection. Following a representation period by the provider we issued a Notice of Decision to cancel the provider. This means the location is no longer active.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: Effective systems were either not in place or robust enough to ensure care was only provided with the consent of the relevant person.

The enforcement action we took:

A Notice of Proposal to cancel the provider's registration was issued following the inspection. Following a representation period by the provider we issued a Notice of Decision to cancel the provider. This means the location is no longer active.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not ensured that people were provided with safe care and treatment.

The enforcement action we took:

A Notice of Proposal to cancel the provider's registration was issued following the inspection. Following a representation period by the provider we issued a Notice of Decision to cancel the provider. This means the location is no longer active.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider and registered manager did not always ensure that people were effectively protected from abuse.

The enforcement action we took:

A Notice of Proposal to cancel the provider's registration was issued following the inspection. Following a representation period by the provider we issued a Notice of Decision to cancel the provider. This means the location is no longer active.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: The provider and registered manager had failed to effectively evidenced that the nutrition and hydration needs of all the people were met.

The enforcement action we took:

A Notice of Proposal to cancel the provider's registration was issued following the inspection. Following a representation period by the provider we issued a Notice of Decision to cancel the provider. This means the location is no longer active.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider and registered manager had not ensured effective systems were in place to assess, monitor, evaluate and improve the quality of the care at the service. Records were not in place to

evidence how the service identified and minimised risks to both individuals and across the service.

The enforcement action we took:

A Notice of Proposal to cancel the provider's registration was issued following the inspection. Following a representation period by the provider we issued a Notice of Decision to cancel the provider. This means the location is no longer active.