A Cox and Mrs Z Cox

# Ashleigh Nursing Home

## Inspection report

17 Ashleigh Road
Leicester
Leicestershire
LE3 0FA

Tel: 01162854576
Website: www.ashleighnursing.co.uk

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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 well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Ashleigh Nursing Home is a care home providing personal and nursing care for up 16 people aged 65 and over at the time of the inspection. The service can support up to 21 people in one adapted building.

People's experience of using this service and what we found
Risks were not always identified, managed or monitored to ensure people were safe and protected from harm. Staff did not have sufficient guidance in care plans and risk assessments. Medicines storage, administration and management were unsafe.

Infection prevention and control procedures did not protect people and staff from the risk of contagious diseases. Health and safety issues were found in relation to the premises and equipment used in the delivery of care.

Further improvements were needed in relation to meeting people's cultural dietary needs and monitoring people's intake of food and drink so action can be taken. People were provided with a choice of meals and their dietary needs had been assessed. People had access to healthcare support when needed.

Systems to protect people's safety and wellbeing was not implemented fully. Staff recruitment procedures were not always followed. People were at risk of receiving unsafe care from staff whose induction and essential training for their roles was not kept up to date and their competency had not been assessed. Increased staffing levels would promote a person-centred approach to care and enable staff to spend more time with people. Systems and processes to protect people from the abuse and improper treatment was not robust.

People did not receive person-centred care and care plans lacked sufficient guidance to enable staff to provide effective care. We could not be assured people were supported to have maximum choice and control of their lives. Mental capacity assessments were not robust or detailed. This meant staff may not be able to support people in the least restrictive way possible and in their best interests. Further action was needed to ensure the policies and systems in the service were followed.

The premises and equipment were not adequately maintained to meet people's needs or promote their independence. Further action was needed to ensure the environment was suitably adapted to support people living with dementia.

The provider did not have effective systems and processes to assess, monitor and improve the quality of service and provide good care. Quality assurance systems had not identified widespread issues in relation to people's care, risk assessments, medicines, infection prevention practices, impacted by staff competence and training and environmental risks. This placed people at serious risk of harm.

The provider and registered manager had not fulfilled their legal responsibilities. Breaches of regulations were found at our inspections of June 2018 and our inspection in August 2019. This demonstrated the lack of lessons learned and limited action had been taken to improve the service as further breaches of regulations were found at this inspection.

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

Rating at last inspection
The last rating for this service was requires improvement (published 5 November 2019). We imposed conditions on the providers registration. The provider completed an action plan after the last inspection to show what they would do and by when to bring about the improvements needed. The service rating has deteriorated to inadequate. Breaches of legal requirements were found, and the service was placed in special measures. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions of Safe, Effective and Well-led which contains the requirement. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashleigh Nursing Home on our website at www.cqc.org.uk.

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 breaches in relation to safe care and treatment, infection prevention and control, safeguarding service users from abuse and improper treatment, premises and equipment, staffing, governance and quality monitoring and failure to submit notifications to the CQC, at this inspection.

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

Follow up
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?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# Ashleigh Nursing 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector, a specialist nurse advisor and an Expert by Experience. The specialist nurse advisor had experience of working and caring for people living with dementia. 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 inspector and the specialist nurse advisor returned on 6 April 2021 to complete the inspection.

Service and service type
Ashleigh Nursing Home 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.

Notice of inspection
This inspection on 1 and 6 April 2021 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 reviewed information we had received about the service since the last inspection. We sought feedback from the commissioners at the local authority and the clinical

commission group (CCG) who work with the service. We used this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with eight members of staff including the provider, registered manager, a nurse, a senior care worker, care workers, the house-keeper and the cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We also made a referral to the local authority safeguarding team and shared information with the fire about our findings.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● There were inadequate assessments of risks to people which meant they were at risk of receiving unsafe care and treatment. For example, there were no risk assessments for a person with known skin damage and a poor intake of food and drink. The electronic care plan had no information displayed for staff to follow. The handwritten care plan was basic and did not have the essential information and instructions for staff in how to meet this person's skin condition and their dietary needs. Records showed the person's skin condition had not been checked and no action had been taken in relation to their poor intake of food and drink. The person was admitted to hospital for treatment.

● People's identified risks were not managed or monitored. A person assessed as 'high risk of developing skin damage, was cared for on a pressure relieving mattress and needed to be re-positioned every two hours. The charts showed the person had not been re-positioned for more than four hours on occasions. Following the inspection, the Provider told us staff also recorded the re-positioning of people in the daily care notes. This showed a lack of oversight and monitoring how risks were managed. The mattress was on a 'firm' setting which was incorrect in relation to the person's weight. This meant the person was at risk of further skin damage.

● Risks associated with people's individual health conditions such as Parkinson's Disease and seizures were not always assessed. For instance, there was no record kept of when a person's catheter was last changed or when the next change was due. This meant people were at risk of receiving unsafe care and treatment.

● People were unable to call for assistance in an emergency. The call bell was found on the floor and out of reach for two people who were cared for in bed.

● Care plans had been reviewed but did not provide sufficient guidance to enable staff to support people living with dementia. When a person living with dementia became distressed staff did not respond, which increased the person's anxiety.

● The provider's fire risk assessment had not been kept under review and had not taken account of changes to the premises. There was an unsupervised fire by the laundry room. We were not assured the provider had taken sufficient steps to reduce risks to people therefore, we made a referral to the fire service for further investigation.

The provider failed to ensure care and treatment was always provided in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities ) 2014.

Preventing and controlling infection

● The provider had not ensured staff were using PPE effectively and safely. The PPE station did not have a 'no touch' clinical waste bin. There were no aprons in the dispenser but hung on the wall hook in the

corridor, which posed a further risk of cross infection.
● Staff told us and training records confirmed some staff received additional training in the prevention and control of infection including donning and doffing PPE. Further action was needed because staff did not always apply the learning and had not adhered to the provider's infection control policy or the government guidance in relation to COVID-19. Staff did not regularly clean the high risk surfaces including the toilets after people had used them. This put people and staff at risk of acquiring contagious diseases.
● Improvements were needed to the premises to reduce the risk of cross infection. For example, the laundry room had exposed brickwork and missing floor tiles. Carpets in the bedrooms were stained and dirty. Armchairs, pressure relieving equipment and bed bumpers had damaged outer covers. This meant people and staff were exposed to the risk of cross infection, which could cause serious harm.
● There were ineffective cleaning regimes despite cleaning sprays and wipes being readily available. The dining room still had old food debris and drink stains on the dining chairs, tablecloths and on the floor. Bedroom carpets, furniture, fittings and equipment used in the delivery of care were stained and dirty.
● The cleaning schedules were not detailed to instruct staff as to the frequency, disinfecting and cleaning in line with the infection control guidance.
● On the second day of inspection we found provider had replaced two damaged armchairs and a pressure relieving mattress and the dining room had been cleaned. However, people and staff remained at risk of infectious disease because further improvements were still needed.

The provider had not ensured people were protected from the risk of infectious diseases. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had put a suitable clinical waste bin by the PPE station when we returned on the second day.
● We were assured that the provider was accessing testing for people using the service and staff.
● Staff told us fire drills took place and records viewed confirmed this. Records showed external contractors had carried out routine servicing and maintenance. These included safety checks on gas and electrical appliances, the passenger lift and equipment used by staff to move people safely, such as the hoist.

Using medicines safely
● At the last inspection we recommended the provider should access and implement good practice guidance around safe medicines management.
● At this inspection we found the medicines storage, administration and management was remained unsafe. The area where the medicines were stored was not secure. Prescribed eyedrops stored in the medicine fridge had not been dated when opened, which is important as they only have a short shelf life once opened. People's personal confidential information regarding their health and medicines such as the medication administration records (MAR) was also accessible to unauthorised people and/or visitors. Prescribed medicines were found in people's rooms, one which had expired in November 2019. This was removed by the registered manager when told. The controlled drugs (CD) register not bound and the loose pages posed a risk of accidently falling out or being removed. Medicines booked in were not always witnessed by a second member of staff, which is good practice.
● There were 12 people who were prescribed 'as required' medicines such as pain relief medicines. However, 11 people had no protocols attached to the MAR charts, which instructed staff as to when and how these medicines should be administered. This included time critical medicines and medicines which had special instructions that needed to be followed. People who received their medication covertly, disguised in food or drink, had no protocol or key documents attached to the MAR chart. These include individual's mental capacity or best interest meeting, GP authorisation and that a pharmacist had been consulted as to the safe method of administration. For example, medicine being given in this way may cause adverse

reactions or not absorbed effectively if more than one tablet was taken together. This could cause significant physical harm to people and increase the risk of medicine errors.

The provider had not ensured people's medicines were managed and administered safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed the nurse on duty administered medicines individually and completed the MAR to confirm the medicines had been administered.
● Following the inspection visit the provider told us about the improvements planned. These included use of an official bound register for controlled medicines and guidance for staff to enable them to administer safely.

At our last inspection the provider failed to ensure people were safeguarded from abuse and improper treatment. 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.

Not enough improvements have been made at this inspection and the provider was still in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse. People who remained in their room were isolated until staff went to support them with personal care or to eat and drink. The lack of stimulation and social interaction impacted on people's mental wellbeing, especially those living with dementia. This has been further compounded by the pandemic.
● Systems and processes were not in place to protect people from the risk of financial abuse. A person told us they gave their bank card and PIN to a member of staff to buy specific items and the staff member confirmed this to be the case. However, there was no signed consent to protect the person from the risk of financial abuse. We made a safeguarding referral to the local authority.
● People were at risk of having their liberties unnecessarily deprived without the appropriate authority. For instance, a person had a Deprivation of Liberty Safeguard (DoLS) authorisation with conditions relating to safe care and treatment which had expired. This person was at risk of receiving improper treatment because appropriate safeguards and best interest assessments had not been completed.
● Care staff and nurses knew what action they would take if they suspected abuse, but this was not the case for ancillary staff. Safeguarding training for some staff was still not up to date.

People continued to be at risk of abuse and having their liberty deprived because robust safeguarding procedures were not followed and staff not fully trained in this area. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● At the last inspection we identified the recruitment process needed to be strengthened and follow the robustly the recruitment procedure.
● At this inspection we found the same issues existed in relation to assessing the applicant's suitability. The application forms in two files were not completed fully in relation to their qualification and employment history. There were no record of the interview questions or the responses, or evidence that any gaps in the application forms and qualifications had been explored. There was no evidence of how the provider had

arrived at the decision the applicant was suitable for the position. This meant people were put at risk because the recruitment process was not robust.

The provider had not ensured people were protected from unsuitable staff. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff had been screened for their suitability to work with people which included a check with the Disclosure and Barring Service, and for nurses, their professional registration.

● We saw staff were busy throughout the day and did not respond promptly when people called out for support. Staff had limited time to spend with people in a meaningful way. People cared for in bed only saw staff when they needed support with personal care or to eat and drink. We saw staff did
● The provider used a dependency tool to calculate staffing levels required to meet people's needs. We could not be assured this was effective due to the lack of accurate and reliable assessments of people's risk and their care needs to base the calculations on. A staff told us they would benefit from an extra member of staff to help provide the support people needed and monitor their safety.

Learning lessons when things go wrong
● The provider had a system to analyse incidents and accidents. A log sheet listed the person, the incident, time and a note about the action taken such as checked by the nurse after a person had fallen. There was no evidence that further checks had been completed to ensure the action taken was appropriate and risks had reduced. The incidents forms were detailed but kept people's individual folder which made it difficult to identify trends, so action could be taken.
● People remained at risk because their health, safety and welfare had been compromised. We identified breaches of regulations at our inspections of June 2018 and our inspection in August 2019. The provider had been supported by the local authority to make some improvements however, the provider was still in breach of these regulations at this inspection.

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 requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider had failed to ensure staff had the appropriate skills and knowledge to meet people's needs and were supervised to ensure they were competent to perform their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements have been made at this inspection and the provider was still in breach of regulation 18.

Staff support, induction, training, skills and experience

- Staff told us they had received some training for their role. The house-keeper told us, "I've not needed any training, cleaning is common sense. I've not had COSHH (control of substances hazardous to health) training, but I was given a COSHH book to read." Most of the training was provided through completion of booklets and e-learning. A new senior care worker had not been advised when the role specific training would be provided.
- Staff induction was limited and related to fire safety, a tour of the premises and key policies and procedure. Nurses' clinical and medicines competency was not checked in a timely way providing health care support and administering medicines.
- Staff training was not kept up to date. The training matrix did not include all staff such as the new nurse and the maintenance staff. External training in infection prevention and control was not included in the matrix nor any evidence to ensure staff practices were safe. For example, staff had not applied fully the learning from prevention and control of infection training and had their competency checked. The provider had identified training had expired, for instance safeguarding and moving and handling but there was no evidence as to what action had been taken to ensure staff were booked on refresher training.
- Staff lacked insight and understanding of how dementia affects people, and their role to provide effective care. For example, staff did not provide any assurance to a person living with dementia who called out for their parent, which increased the person's anxiety. The majority of staff had not received training in dementia care to enable them to understand how living with dementia affects people.

The provider had not taken sufficient action to ensure staff had the appropriate skills, knowledge and were competent to meet people's needs effectively. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● A person described the environment as, "It's a bit tatty." Bedrooms were not personalised to reflect what was important to people. The environment was not adapted to support people living with dementia. There was limited dementia friendly directional signage to assist people with orientation around the building. The bedroom doors had no names of people or a photograph, and no memory boxes to enable people living with dementia to locate their bedroom. The passenger lift was disguised as the entrance to a post office. Although no incidents had been reported, a person could be disorientated if they entered the lift and were unable to use the buttons to get out.
● The premises and equipment had not been maintained properly to meet people's needs or promote their independence. For instance, damaged and missing flooring, inadequate lighting as missing light bulbs had not been replaced in the ceiling light on the landing, and a boarded-up window in a bathroom. Armchairs and equipment such as specialist chairs and pressure relieving equipment were damaged and not fit for its intended purpose.
● The provider identified bedrooms that needed to be decorated but there was no evidence people had been consulted about this. Some decoration had started in the lounge and a bedroom but was still not completed. The outdoor space was a small lawn and an area with some plants next to the concrete driveway. The seating was not suitable. This showed the premises and facilities were not well maintained, adapted or designed to have a positive impact on people's wellbeing.

The provider had failed to suitably adapt and maintain the premises and equipment to meet people's needs. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had replaced the flooring in the reception area and the lounges. One bedroom had been converted to a visitor room to enable relatives to visit family members safely.

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 found the service was not always working within the principles of the MCA. Applications had been made to the local authority for DoLS authorisation, however, conditions were not always met.
● The registered manager and staff had been trained in this area and mostly sought people's consent. However, they were unable to tell us about the DoLS conditions and how those were being met. The system used to monitor the DoLS renewal was not effective as one had expired but there was no evidence that a renewal had been submitted. We raised this with the provider.
● A person told us they were involved in decisions made about their care. However, records did not always show people's capacity to make decisions had been assessed. Decisions made in people's best interests including the involvement of other people such as relatives and health care professionals, were not always recorded.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments were not always completed in line with the provider's admissions policy and best practice guidance. The registered manager relied on the assessments from the local authority and the hospital to

determine whether they could meet the needs of people before they moved to the service. However, any known risks to people and their health conditions were not effectively managed because risks assessments were not in place.

● A person told us they had been involved in the development of the care plans. However, the care plan did not reflect the decisions made were not sufficiently person-centred to enable staff to provide the optimum care. For example, how people wished to be cared, their morning and bedtime routines and what they like to wear. Further information about people's individual characteristics under the Equality Act 2010 and other diverse needs such as cultural preferences would enable staff to promote people's wellbeing.

● Improvements were required to ensure people were able to complete meaningful activities of interest. A few people were seen colouring shapes, but there were no planned group or individual activities or engagement with people who were cared for in bed.

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

● People's dietary needs had been identified but we could not be assured the menus took account of any cultural dietary needs such as vegetarian or Asian meals.

● People at risk of malnutrition or dehydration had a food and drink intake chart put in place. Staff recorded what people had to eat and drink but this was not monitored so action could be taken.

● There was a choice of meals provided. A person said, "The meals are ok but could be better." People had enough to eat although the meals did not look appetising. People who needed support to eat had to wait for staff to support them, which they did once all the meals had been served in the dining room. It was evident that some people ate food that had cooled down.

● The kitchen staff had information about people's dietary needs such as different textures and food tolerances.

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

● People's health was monitored and referrals were made to health care professionals when required. The registered manager told us the GP had visited when people's health was of concern. Records showed treatment provided by health care professionals such as the GP,  dietician and the chiropodist had been received by people.

● During the pandemic the registered manager had been working with the local authority to improve the reviewing of people's care.

Inadequate

# Is the service well-led?

## Our findings

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

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

At our last inspection the provider failed to ensure they had effective systems to monitor the quality of service provided. This was a continued 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.

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

- The management structure was not robust to manage the running of the service effectively. The registered manager told us the provider was responsible for the prevention and control of infection, despite this being equally important in relation to meeting people's care needs safely. The registered manager told us they needed to allocate lead responsibilities for nurses such as clinical care and medicines management but had not taken action to progress this.
- The provider had displayed the last inspection report and rating at the care home. The provider did have a website but it was not active. We will continue to monitor this.
- The provider had carried out a range of audits and checks on premises but failed to identify and manage issues relating to health and safety, and risks to people and their care needs which we found. Action plans were not monitored to check the progress of improvements. We identified deficiencies in prevention of infection and control practices, which had not been identified through the provider's infection control audits.
- Oversight of people's care including risk assessments, care plans and monitoring records such as food and drink intake and repositioning charts, were not effective. The electronic care planning system was not kept up to date or was incomplete. The review of people's care was ineffective as risks were not monitored and gaps in record keeping had not been identified. This meant people did not receive safe and well managed care that met their needs.
- The provider had not fully implemented the policies and procedures and there were no checks to ensure staff followed those. The handover meetings were used to update staff about changes to people's needs, as risk assessments and care plans were not reliable or in place in accordance with the admissions policy.
- The system in place to monitor the safe management of medicines was not effective. The quality audits had not identified concerns about the storage, recording and administration of prescribed medicines. This meant people's health was put at serious risk.
- Safeguards were not in place to protect people from the risk of abuse and their legal and human rights

were deprived. The provider had not fully met DoLS authorisation and conditions, monitored renewals, and taken appropriate action in the person's best interest.
● The provider had not made the required improvements in relation to staff recruitment process which we identified at the last inspection. Systems to ensure staff were trained in safety, knowledgeable and competent was not effective. The provider had identified staff training had expired but no further training had been booked to ensure staff had up to date skills, knowledge needed and were competent to meet people's needs. Not all staff were trained to support people living with health conditions such as dementia.
● The provider had failed to use the findings from our last two inspections to drive enough improvements. The provider's monthly reports submitted to the CQC did not support what we found during this inspection. This demonstrated the provider and registered manager had not consistently met their legal requirements in relation to the continued and further breaches of the Health and Social Care Act 2008.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● People's care that was task orientated and lacked a person-centred approach. The registered manager told us everyone was on hourly checks. However, the frequency of these checks was not increased for a person with a chest infection and visibly needed support more often.
● The provider had failed to use the findings from our last two inspections to drive enough improvements. The provider's monthly reports submitted to the CQC did not support what we found during this inspection. This demonstrated the provider and registered manager had not consistently met their legal requirements in relation to the continued and further breaches of the Health and Social Care Act 2008.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives had limited opportunities to express their views about the service or influence changes. The last 'residents meeting' took place in September 2020. Satisfaction surveys had been returned at the same time and were filed. The provider had not analysed the responses from a person using the service, staff and professionals to identify any trends so action could be taken until we asked the provider about this. It was evident the results from the survey had not been shared with people using the service, their families and staff.
● Staff told us they were supervised and the provider had not raised any concerns about their performance. Staff did not always follow procedures. There was limited evidence to confirm staff competency had been checked in relation to moving and handling of people, providing person-centred care and administering medicine. Staff meetings took place but there was no record of the topics discussed to provide assurance that staff were kept up to date about people's care and any improvements planned.

There were ineffective systems and processes to ensures effective management oversight of the quality assurance of all aspects of people's care and the service. This was a continued breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider and registered manager told us they understood their responsibility under the duty of candour to be open and honest when things went wrong. However, we were not assured of this because all notifiable information had not been reported to the CQC such as serious injuries, incidents or allegations of abuse. The registered manager told us they recently learnt that they needed to notify the CQC of all Deprivation of Liberty Safeguard (DoLS) authorisations. Our records confirmed the provider had not submitted DoLS notifications as required.

This is a breach of regulation 18 Notification of other incidents of the Care Quality Commission (Registration) regulations 2009 (Part 4)

● The provider and registered manager had identified some shortfalls through their own audits. The provider acknowledged improvements were needed and indicated their commitment to make improvements but had no plan in place.
● Staff told us the provider and registered manager were approachable and supportive.

Working in partnership with others
● People's care records showed they had access to healthcare and other professionals such as GP and the chiropodist.
● The provider had been supported by the local authority after the last inspection and during the COVID-19 outbreak at the service. However, further improvements was required because the provider's systems and processes were not effective to drive improvements to the service needed.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider and registered manager had not submitted timely notifications which they were legally required to do so. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had not followed robustly staff recruitment procedures to protect people from unsuitable staff. |

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to ensure risks associated with people's care had been identified, mitigated and monitored.<br><br>The provider failed to ensure people medicines were stored, administered and managed safely.<br><br>The provider failed to ensure people were protected from the risk of infection. |

**The enforcement action we took:**

We issued a Notice of Decision to cancel the registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider failed to ensure robust safeguards were in place to protect people from abuse, and the undue deprivation of people's legal and human rights. |

**The enforcement action we took:**

We issued a Notice of Decision to cancel the registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure the safe care and treatment of people.<br><br>Risk assessments were flawed as the systems and processes to assess and review risks was inadequate. Potential risks were not mitigated. Risk assessments were not reviewed with consideration to changes in people's needs nor as |

| | |
|---|---|
| | a result of accidents or incidents.<br><br>The medicine administration process was not robust. The safe management of medicines was not effective to ensure medicines were stored and administered safely.<br><br>The provider failed to robust systems and processes were in place to effectively monitor, identify and address shortfalls in the quality of service. The registered manager did not have oversight of the quality of care. |

**The enforcement action we took:**

We issued a Notice of Decision to cancel the registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to have robust systems were in place to ensure safe staff recruit processes were followed. Staff were not fully trained in their roles to ensure they had the skills and were competent including the prevention and control of infection and training was not monitored. System for supporting staff was not robust. |

**The enforcement action we took:**

We issued a Notice of Decision to cancel the registration.