Ms Lynda Martin

The Newlyn Residential Home

Inspection report

2 Cliftonville Avenue
Ramsgate
Kent
CT12 6DS

Tel: 01843589191

Date of inspection visit:
31 October 2019
01 November 2019

Date of publication:
18 December 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Newlyn Residential Home is a residential care home providing personal care to 12 people aged 65 and over at the time of the inspection. The service can support up to 13 people.

People's experience of using this service and what we found
People's views of the service varied, some people told us staff were caring and they were happy at the service. Other people were not completely satisfied with the care they received. One person told us, "It is so variable. You have the understanding type (of staff) and some that don't have the natural instinct to do the job". We found leadership at the service was poor and staff had not been supported to provide consistently safe and effective care. We did not find harm had come to people but people were at risk.

The provider did not have oversight of the service. They were not working at the service at the time of our inspection. Regular comprehensive checks had not been completed on the quality of the service. The provider was unaware of the shortfalls we found at the service and they had continued.

The provider was isolated and had not taken up opportunities to develop themselves and the service. They understood their legal responsibilities but had not ensured we were notified of significant events that happened at the service. People and staff had not been asked for their views, some staff felt they were not listened to.

People's medicines were not managed safely. Guidance was not available to staff about some medicines. Medicines records were incomplete.

Risks to people had not been fully assessed. Some risk assessments were the same for everyone and did not reflect people's individual needs and wishes. Risk relating to people falling or developing pressure ulcers had not been assessed.

People were not protected from the risk of fire as some staff were not confident to use evacuation equipment and equipment was not checked regularly. Processes were not in operation to learn lessons when things went wrong.

People were not fully protected from the risks of harm and abuse because some staff did not know how to raise concerns to authorities outside of the service. There was a risk people who choose to remain in their bedroom were isolated. Robust assessments of people's needs had not been completed and used to plan their care.

Staff had not been trained to provider oral hygiene care. Guidance was not in place for staff and people did not see a dentist regularly. Guidance was not in place about everyone's health care needs. Staff promptly contacted healthcare professionals when people's needs changed.

Staff were not recruited safely and did not complete a comprehensive induction. Staff had not been supported to develop all the skills they needed. There were enough staff to meet people's needs.

People were not always referred to respectfully. They had not been asked about their lifestyle and equality needs and choices so they could be understood and respected. We have made a recommendation about person centred care, communication, occupation and risk assessments.

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.

People had privacy but were not always referred to in respectful ways. Information had not been obtained about people's equality and diversity needs to ensure they were supported in respectful ways.

People had not been offered the opportunity to discuss their end of life preferences. Some people did not know how to complain about the service. One person's complaint had not been resolved.

People were supported to eat and drink enough.

The service was clean and people were protected from the risk of infection. The environment had been designed to meet people's needs.

People were supported to remain independent and were involved in caring for pets. Staff treated people with caring and compassion

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

Rating at last inspection (and update)
The last rating for this service was good (published 25 April 2017).

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

Enforcement
We have identified breaches in relation to governance and leadership, staff development and support, medicines, person centred care, complaints handling, recruitment and notification of significant events at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Newlyn Residential Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was completed by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Newlyn Residential 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

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 used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and two relatives about their experience of the care provided. We spoke with five members of staff including the manager, deputy manager, two care workers and the chef.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. We also looked at a variety of records relating to the management of the service, including staffing rotas.

After the inspection
We spoke with the provider. We viewed documents to deputy manager sent us, including staff training records and the provider's statement of purpose.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● People were at risk because their medicines were not managed safely. Processes were not in place to account for all medicines and ensure they were managed safely. We found a loose tablet in the medicines trolley. Staff could not tell us what the medicine was or who it belonged to. The manager told us the medicine may have "fallen out" of a blister pack or been "dropped" and "lost" by staff. They did not understand the risks this posed to people. Records of the number of tablets kept in stock were not maintained.

● A community pharmacist completed an audit of medicines in August 2018. They found handwritten medicines administration records had not been double signed to check they were correct. They also found the date of opening had not been recorded on boxes and bottles of medicines. We found the same shortfalls. Effective action had not been taken when medicines records were found to be incomplete and this continued. For example, records had not been completed to confirm one person's cream had been applied on 17 occasions in October 2019.

● Effective processes were not in operation to manage pain relief patches. Guidance had not been provided to staff about where to apply patches and when. The position on the body where pain relief patches had been applied was not recorded. Placing the patch in the same place increased the risk of skin damage and the medicine not being effective. Staff told us they placed the patch in a different place each time and no one had any skin damage.

● There was a risk people would not be offered their 'when required' medicines safely or when they needed them. We observed people being offered these in a kind and caring way. However, staff did not have guidance to follow about the signs people may need their medicine or the maximum does in a 24 hour period.

We found no evidence that people had been harmed however, effective procedures were not followed to store, administer and record of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were not recruited safely. Criminal record checks with the Disclosure and Barring Service (DBS) had been completed. Any disclosures on DBS checks had not been risks assessed to ensure staff were not a risk to people. This had not impacted on people living at the service.

● Checks on staff's previous employment including references had been obtained. Any verbal references taken had not been recorded to demonstrate what had been said and by who. Applicants had not provided

the full employment history with any gaps and action had not been taken to obtain this. This information helps providers understand staffs skills, experience and character and employ suitable people.

We found no evidence that people had been harmed however, safe recruitment processes had not been followed to ensure staff were of good character. This placed people at risk. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's needs. One person told us, "Whenever I needed anybody, I never had a problem". The provider considered people's assessed needs when deciding how many staff to deploy on each shift. There were staff vacancies and the provider and staff often covered extra shifts to ensure people were safe. The manager spent a lot of time trying to cover shifts during our inspection.
● Staff knew people well and responded to their requests for support promptly.

Assessing risk, safety monitoring and management
● Risks to people had been not been fully assessed and written guidance had not been given to staff about how to minimise all risks. Most risk assessments were the same for everyone and did not reflect people's needs. Some guidance was available to staff about how to reduce risks to people, such as the type of hoist and sling. However, this did not cover all the risks.
● Some people were at risk of developing pressure ulcers and needed to move often. Guidance was not available about how often to support people to move or how to use pressure relieving equipment. Records for one person showed they had not been supported to move between 18.00 and 06.30. Their pressure equipment had not been checked to make sure it was working correctly. This had not impacted on people and no one had a pressure ulcer. However, it did increase the risk to people.
● Risks of people falling had not been assessed but staff had identified who may fall. One person staff said was at risk had fallen three times in October 2019. They had not been referred to their GP and staff monitored them "the best we can". When falls monitoring equipment, such as pressure mats had not reduced the risks to people, further action had not been taken to keep them safe. People at risk of falling from their bed used bedrails to keep them as safe as possible.

We recommend the provider consider current guidance in relation to person centred risks assessments.

● Risks relating to fire had not been fully assessed and action had not been taken to reduce them. Everyone had a personal emergency evacuation plan (PEEP). PEEPs in some people's care plan records differed from the PEEP in the emergency fire folder. Regular checks of the fire system had not been recorded since August 2019. One fire exit led to an enclosed courtyard with a locked gate. During the inspection the lock was changed to make sure it could be opened quickly in an emergency.

Learning lessons when things go wrong
● Processes were not in place to analyse accidents. Information about accidents was recorded over different documents and did not give a full picture of what happened. People were not having frequent accidents.
● The deputy manager planned to implement a system to audits falls at the end of November 2019. The audit contained an overview of the number of falls each person had had but not the time or place. This information is needed to identify any patterns and trends. The form referred to the completion of falls risk assessment however these were not in use at the service.

Systems and processes to safeguard people from the risk of abuse
● Processes were in place to protect people from abuse. However, some staff did not know how to blow the

whistle about any concerns they had outside of the service.
● Some staff had not completed safeguarding awareness training. Staff we spoke with knew about different types of abuse and were comfortable to report any concerns to the management team.
● The management team knew about local arrangements to discuss any concerns about people's safety with the local authority safeguarding team. When necessary action had been taken to prevent incidents occurring again.

Preventing and controlling infection
● People were protected from the risk of infection. The service was clean and odour-free. One relative told us, "It is always clean and immaculate".
● Most staff had received training in food hygiene and infection control. They used personal protective equipment such as gloves and aprons, when required.
● When people were at risk of developing infections, staff followed guidance to reduce this risk.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff had not completed an in-depth induction. They were not supported to understand the service and develop the skills they needed to provide safe and effective care. New staff completed a one day induction and shadowed other staff to get to know people. Their competency to support people was not assessed during the induction. One staff member told us they did not feel confident in their skills after their induction and found the role "daunting". Another said, "I can't remember it all, it was a lot to take in at once".
- Staff who had not worked in care before had not completed the Care Certificate. This is an identified set of standards that staff adhere to in their daily working life. Staff knew how to support people to evacuate to a safe place in an emergency. However, some staff had not practiced using evacuation equipment and were not confident to use it.
- Staff's competence to provide people's care was not regularly checked. For example, staff's knowledge, skills and competencies relating to managing and administering medicines were not reviewed annually as recommended by the National Institute for Health and Care Excellence.
- Staff completed training in some areas appropriate to their role including topics specific to the needs of the people they supported such as diabetes. We observed staff supporting people to check their blood sugar levels and take action when they were outside of the normal range.
- Staff had not met regularly with a supervisor to discuss their practice and development. One staff member had not received supervision in the two months they had been employed. Another who was new to care, had received one supervision in 10 months of employment. They told us they did not understand the meeting or why it was held. The purpose of supervision is to give support to staff to help them progress and feel comfortable in their role.

We found no evidence that people had been harmed however, staff had not been supported to develop the skills and knowledge required to fulfil their role. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Two members of the management team met with people and their relatives to discuss their needs before they began to use the service. Information about what people were able to do for themselves and what support they required from staff was not recorded. For example, the support they needed to move around and any assistance with eating and drinking. Staff knew what support people required and we observed people were offered support when they needed it.
- People were not given the opportunity to share information about any protected characteristics under the

Equality Act 2010, such as race and gender.
● People's needs had not been assessed using recognised tools. For example, to understand their risk of developing pressure ulcers or becoming malnourished. The provider took action after our inspection to obtain and use these.
● People and their relatives had been asked to share some basic information about people's lives before they moved into the service to help staff get to know them and understand what they liked. However, detailed information about people had not been requested so staff could plan people's care with them around their life experiences, wishes and preferences. Staff spoke with knowledge about people and things which were important to them.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff had not completed training in oral healthcare and guidance was not available about people's needs. One staff member told us, "No one has checked to make sure I'm doing it right". Two people were having problems with their dentures and were supported to use adhesive. Staff told us this had helped. They had not seen a dentist to make sure they dentures still fitted them. No one had been offered a dental check. The management team were not aware of the National Institute for Health and Care Excellence or Care Quality Commission guidance around oral healthcare.

We found no evidence that people had been harmed however, the provider had not planned people's oral care to make sure they received effective care to keep them as well as possible. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Guidance had not been included in people's care plans to ensure they received treatment in a timely way. One person was prescribed antibiotics for frequent infections. A stock of the medicine was kept at the service to be given over the weekend when a prescription was more difficult to obtain. However, an anticipatory care plan was not in place to inform staff about the signs the person may have an infection, or what to do if the medicine was not effective. The deputy manager knew they signs the person needed the medicine and was on call when they were not at the service. Staff told us they were confident to call them for advice.
● People and their relatives told us staff called their doctor or emergency services when they were unwell. One person told us, "They thought I'd had a heart attack and called an ambulance straight away". Staff monitored people's health and referred them to relevant health professionals when their health needs changed. Such as, referrals to community nurses if people's skin looked sore. Health professionals' advice was recorded and shared with staff. People were supported to follow their advice.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being

met.
● The management team were not aware of their responsibilities under the MCA. The manager and deputy manager had completed training but "nothing in depth". They were unclear about when to apply for a DoLS. The deputy manager told us a DoLS was only required if the person asked to leave the home. They had not considered other restrictions. One person used bedrails and a 'disclaimer' for their use had been signed by a relative. The person's capacity had not been assessed and a decision had not been made in their best interests. A DoLS had not been applied for despite the person being restricted.
● The provider had signed consent forms on people's behalf. They had signed a consent form including medicine administration, being weighed, care and treatment and the storing and sharing of information. Again, the person's capacity to understand and make decisions about these things had not been assessed. Decisions had not been made in their best interests or by people with the legal authority to do so. Some people had appointed attorneys to make decisions on their behalf. Staff did not know what type of decisions could be made why who.
● Community nurses were due to visit the service shortly after our inspection to administer flu vaccinations. People's ability to consent to having the vaccination had not been assessed. The decision for people to have the vaccination had not been made in their best interests, including any previous decisions.

We found no evidence that people had been harmed however, the provider had not ensured people were lawfully restricted. They had failed to assess people's capacity to make decisions and ensure any decisions made on their behalf were made in their best interests. This placed people at risk of harm. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's care plans did not contain guidance for staff about the support people needed to make decisions. However, staff were able to describe to us how they supported people making day to day decisions. We observed the cook showing people meals to help them understand the choices available to them.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough. People told us they liked the food at the service. Their comments included, "The food is jolly good. No complaints what so ever" and "The Chef is very good". Their needs were catered for including diabetic diets.
● People were supported to eat at a time which suited them. One person told us, "I don't always have an appetite. We are trialling me eating the main meal at 4 pm, which is better". People were able to choose when and where they ate. When people wanted an alternative, these were prepared for them. We observed several different meals were prepared at lunch times.
● Staff knew about people's preferences such as if they liked small meals and made sure their meals were prepared in the way they preferred. People were involved in planning the menu and the chef chatted regularly to people about what they liked. Liver, smoked haddock and poached eggs and kippers at been offered a people's request.
● People who were at risk of losing weight were referred to the dietician and their advice was followed. Staff followed recognised best practice guidance for people at risk of losing weight and offered people food fortified with extra calories.

Adapting service, design, decoration to meet people's needs
● The building had been decorated to meet people's needs. People were encouraged to decorate their bedrooms with personal items, such as pictures and ornaments.
● The furniture was suited to people's needs and people told us it was comfortable. Staff supported people

to use cushions to support them to be comfortable. People were able reach drinks and snacks as the side tables were the correct height.

● Areas of the garden were accessible to people and people spent time there in the summer.

● The first floor was accessible by a stair lift. Rooms on the first floor were only offered to people who were able to use the stair lift or walk upstairs.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- People and their relatives had not had opportunities to chat about their lifestyle choices, sexual orientation and gender identity. This is important so staff can respect people's choices and ensure they are treated equally and with respect.
- The management team and staff did not always refer to people in respectful ways. For example, people's care plans described them as needing 'feeding', rather than requiring assistance to eat and drink. People who required two staff to support them at times were referred to as 'doubles'. Staff referred to people by their preferred names.

We recommend the provider consider current guidance on person centred care, including dignity and respect.

- Staff knew people well and spent short periods of time chatting with them. For example, one person enjoyed sport and chatted with the cook about a cup final happening the next day. People and staff were relaxed in each other's company. We observed people and staff laughing together on occasions.
- Staff treated people with kindness and compassion. We observed staff chatting with people in a kind and gentle way. When one person had trouble swallowing their tablets, a staff member sat next to them and reassured them. They spoke to the person calmly and the person was reassured and swallowed the tablets. Another staff member moved a table closer to a person before they began to eat their meal. The explained clearly what they person needed to do, saying, "Raise your feet as I push the table. That's it. Now lift the left one, that's it, well done, now the other one, that's it".

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

- Choices people had shared with staff such as where people preferred to spend their time were respected. For example, some people preferred to remain in their bedroom. Staff respected people's decisions but did not visit them often to make sure they were not isolated.
- Staff supported people when they were anxious. One person worried about the pet cats that lived at the service and liked to feed them. They had agreed feeding times with the staff. We observed them getting the food and feeding the cats at the agreed times. Staff chatted to the person throughout the day about the cats and told the person where they were when they looked for them. This reassured the person.
- People who needed support to share their views were supported by their families or paid advocates. Staff knew people's advocates and how to contact them when needed.

Respecting and promoting people's privacy, dignity and independence

● People were encouraged to be as independent as possible and do things for themselves. People's comments included, "When I fell a few weeks ago they were great with helping me, but generally I do it myself" and "They offer [my relative] a hair brush to brush their hair to see if they can still do it and also with the toothbrush too".

● People were supported to maintain relationships which were important to them. Visitors were welcomed and continued to care for their relative when they wanted to. One relative told us, "I can come whenever I want".

● People had privacy and received their care in private. They were able to spend time with friends and relatives alone.

● The provider knew about data protection regulations and kept personal, confidential information about people and their needs safe and secure.

Requires Improvement

Is the service responsive?

Our findings

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

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

Improving care quality in response to complaints or concerns

- A process to receive, investigate and respond to complaints was in place but had not been followed. One person told us they had complained to the provider they were cold in their bedroom and asked for a heater. The complaint had not been recorded and resolved. We visited the person in their room and they told us they were cold. The room was not warm and the radiator was not hot. We discussed this with the management team who arranged for the person's radiator to be turned up.
- Some people did not know how to complain. However, other people were confident to raise any concerns with the management team, one person told us, "They are always very approachable. The owner, the Manager and the carers".
- Information about how to make a complaint had not been given to people in ways they understood.
- People were not given opportunities to discuss any concerns they had. For example, at residents' or keyworker meetings.

The provider had not ensured that everyone was confident to raise any concerns or complaints they had and act on any complaints received. This placed people at risk of harm. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- The management team were not aware of AIS. Information was not available to people in formats they could understand, such as large print or pictures. Action had not been taken to make sure people with sight loss had all the information they needed about the service.
- Information that people may wish to refer to, such as the menu for the day, was not available. People had to rely on asking staff and being told the information.

We recommend the provider consider current guidance in relation to effective communicating for people living with dementia or with sensory loss.

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

- Some people were isolated in their bedrooms and did not have the opportunity to take part in pastimes

they enjoyed or spend time with others. One person told us, "I don't go out. I normally sit and watch television. It is on all day". Another person at risk of falling told us the only activity they did was walk around their bedroom without staff support.

● People were not supported to continue to take part in household tasks such as folding their clothes or preparing drinks and snacks. One person was able to prepare their breakfast and hot drinks before they moved into the service. The deputy manager told us the person had not offered the person the opportunity to continue to do this.

● An activities person offered group activities in the lounge. Some people joined in with these and told us they enjoyed them. One person told us, "We have activities every afternoon. A lady comes in and we play games, quizzes and sing things. She also reads for about half an hour a day from a book she buys and she is very good".

We recommend the provider consider current guidance in relation to supporting people to remain active and occupied.

End of life care and support

● People and their relatives had not been given the opportunity to fully discuss their end of their life preferences. Some people had end of life care plans in place which the deputy manager described as 'vague'. They included where people wished to be and that they did not wish to be alone. Other important information such as people's cultural or spiritual preferences had not been discussed. One person's plan included when they wished their relatives to be contacted. Following our inspection the provider put plans in place to obtain and record peoples end of life preferences.

● People who wanted, were supported to remain at the service at the end of their life by community nurses. Pain relief and other end of life medicines were held at the service and community nurses administered these when they were required.

● People's relatives were able to stay with their loved one at the end of their life if they wished and were supported by staff.

● People had been supported to make advanced decisions such as not to have cardiopulmonary resuscitation (CPR) with their relatives and health care professionals.

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

● People knew there were care plans about them but had not been involved in writing them. There was some guidance for staff to follow about how to provide people's care. Such as, how to support people to get dressed if they did not have full movement in their arms. However, detailed guidance had not been provided about all areas of people's care.

● Staff knew people's likes and dislikes, such as their favourite food and how they liked them served. One person disliked cold food and drinks and staff always offered them hot drinks.

● Plans were in place to gather information from people and their relatives about their life before they moved into the service. The aim was that this information would support staff to tailor people's care more around them and their preferences. Relatives told us they were informed about any changes in their loved ones needs. One relative said, "They always call me if there is ever any problem".

● Some people preferred to spend time in their bedroom and others had preferences about how their bed was made. Staff knew people's preferences and made sure they received support in the way they liked.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider was not managing the service at the time of our inspection and was not expected back for several weeks. They had delegated tasks to the manager and deputy manager. However, there was a lack of clarity around who was responsible for what and some staff told us they did not know who to discuss issues with. One staff member said, "It's always a bit of a nightmare knowing who to tell". The provider had written job descriptions for each member of the management team, however, this had not been effective and there was no clear leadership at the service. Regular staff meetings and one to one meetings were not held to discuss staff's performance and remind them of their responsibilities.
- The management team did not understand the principles of an effective quality assurance process and a robust system of checks and audits was not in operation. For example, an analysis of accidents had not been completed to identify risks and take action could be taken to stop them happening again. The management team were not aware of the shortfalls we found.
- The provider did not have a robust process in operation to audit medicines and take action to make improvements. Medicines records were checked monthly but no other checks were completed. Checks in August and October 2019 identified a number of gaps in medicines records. Despite the management team "telling staff again and again" and sending memos, there has been no significant improvement.
- Records were not accurate and complete. The provider was aware of some of the shortfalls, such as gaps in medicine administration records. They were not aware of other gaps including guidance missing from risk and needs assessments.

We found no evidence that people had been harmed however, the provider had not ensured a robust quality assurance process was not in operation to continually understand the quality of the service and ensure any shortfalls were addressed. Records about people were not complete. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the provider asked the deputy manager to begin making the necessary improvements to the service. They sent us an action plan which included further training and competency assessments for staff, and obtaining detailed information during staff recruitment. We will check the action the provider has taken is effective at our next inspection.

● Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This is so we can check appropriate action had been taken. The manager was responsible for informing CQC of notifiable events in the providers absence. They did not fully understand their responsibilities and we had not been notified of at least four significant events in 2019. The manager told us, "I was under the impression we only had to do unexpected deaths".

The registered person had failed to notify us of three deaths that occurred at the service. This was a breach of regulation 16 (Notification of death of service user) of the Care Quality Commission (Registration) Regulations 2009.

The registered person had failed to notify us about the outcome of a Deprivation of Liberty Safeguards application. This was a breach of regulation 18 (Notification of death of service user) of the Care Quality Commission (Registration) Regulations 2009.

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

● People, their relatives, staff and professionals were not engaged or involved in the service. They had not been regularly asked for their experiences to support the service to continually improve. We were shown some completed questionnaires which people had completed with staff. An analysis had not been completed. The management team had not considered people may not feel confident to raise concerns about the staff team as they were with them. The feedback was positive however, the forms were not dated and the management team did not know if they reflected people's current views.

● People were not asked for their views or suggestions at residents' meetings. The last meeting had been held in June 2018. No further meetings were planned.

● Staff did not have regular opportunities to meet with colleagues and the management team to discuss practice or suggest changes. Some staff told us they did not feel empowered as suggestions they made had not been considered by the management team. One staff member told us they did not feel their "opinions were valid".

We found no evidence that people had been harmed however, people, their relatives and staff had not been asked for their views of the service to drive improvement. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider did not have a clear vision of the service. Staff were not able to tell us what the philosophy of care was. The provider's statement of purpose contained a heading 'care objectives' but these had not been described. We would expect a service to be based on a set of values including involvement, independence, respect and equality.

● One staff member told us they thought the vision for the service was "protecting people from harm". The did not understand how to support people to consider and take risk if they wished. For example, they told us no one at the service was 'allowed' to have a bath without staff present because they may drown. Risk assessments did not support this view. When asked, the staff member agreed that most people were safe to sit in a chair or bath without supervision.

● Some staff told us they were not motivated and did not feel appreciated. One staff member told us staff were "left to get on with it" and they did not think they were making a difference to people's lives.

● Some staff, including the provider were working long hours to cover staff vacancies. Staff did not always

work as a team and there had been some tensions between staff members. Action had not been taken to monitor staff relationships. Minutes of a staff meeting in April 2019 referred to staff not having positive and cooperative working relationships, however this had not been followed up to make sure staff relationships had improved.

Working in partnership with others

●The management team were isolated. They did not regularly participate in meetings, groups or forums, such as the registered managers' network, to develop their knowledge and the service.

● The management team and staff did not take advantage of educational opportunities offered by the local Clinical Commissioning Group (CCG). Topics covered in 2019 included falls, the Mental Capacity Act 2005 and safeguarding, areas that required improvement at the service.

● The local CCG had invited the service to join a project working with people's GPs and a consultant to put anticipatory care plans in place. This work had not begun at the time of our inspection and we will check to see what improvements have been made to people's care at our next inspection.

● Staff worked with people's community nurses and GPs to monitor and maintain their health.

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 understood their duty of candour and had been open and honest with professionals, such as safeguarding staff, when things had gone wrong.

● Following our inspection, we spoke with the provider and they took full responsibility for the shortfalls at the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered person had failed to notify us of three deaths that occurred at the service. 16(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had failed to notify us about the outcome of a Deprivation of Liberty Safeguards application. 18(1)(4A)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to plan people's oral care to make sure they received effective care to keep them as well as possible. 9(1)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people were lawfully restricted. They had also failed to

assess people's capacity to make decisions and ensure any decisions made on their behalf were made in their best interests.

11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to operate effective procedures to store, administer and record of medicines. 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure everyone was confident to raise any concerns or complaints they had and act on any complaints received. 16(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ask people, their relatives and staff for their views of the service to drive improvement. The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. Records about people were not complete. 17(1)(2)(a)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care	proper persons employed The provider had failed to operate safe recruitment processes to ensure staff were of good character. 19(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not supported staff to develop the skills and knowledge required to fulfil their role. 18(1)(2)(a)