Interhaze Limited

Stanbrook Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Stanbrook Care Home is a residential care home providing personal care to 16 people aged 65 and over at the time of the inspection. The service can support up to 25 people.

The care home accommodates people over two floors which were accessed by a lift in one adapted building. It provides care to older people, some of whom are living with dementia and mental health needs.

People's experience of using this service and what we found
Safeguarding concerns had not always been raised and investigated appropriately and the information not always shared with the local authority or CQC. Similarly, accidents and incidents were not always followed through with the appropriate action to minimise the risk of re-occurrence. The service was working with the local authority to improve practice in this area. People told us they did not feel safe living in their home. Risks had not always been assessed to keep people safe and protected. There was insufficient guidance available for staff to ensure that people's health conditions were managed appropriately to protect people from potential risks. People told us they received their prescribed medicines.

We received mixed feedback from people in respect of meals. People did not have a pleasant meal time experience. People were given limited meal choices for breakfast. People's health care records did not contain sufficient information and guidance for staff to follow. People felt staff had the skills and experience to care for and support them. 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 told us they were not always treated with kindness and compassion by staff who supported them. People were not consistently supported to make choices about their lives. We saw instances when people's privacy, dignity and confidentiality were compromised.

People did not receive personalised care that was responsive to their needs. People told us they did not contribute to the planning and reviewing of their care. There were limited opportunities for engagement and stimulation for people daily and within their local community. People could not be confident that their wishes during their final days and following death would be understood and followed by staff.

The management of the service was inadequate as the provider did not carry out robust checks to ensure that care was being delivered safely and effectively. The registered manager carried out audits of the service, but these had failed to ensure that people were always safe and that their needs were being met. People and their relatives told us the service had improved but had a long way to go.

Rating at last inspection
The last rating for this service was Inadequate (published January 2019). Since this rating was awarded the registered provider of the service has changed. We have used the previous rating of inadequate to inform

our planning and decisions about the rating at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Angel Court on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, person-centred care, safeguarding service users from abuse and improper treatment and the governance of the service.

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

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

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

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?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Stanbrook Care Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector, one assistant 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
Stanbrook Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information helps support our

inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and five relatives about their experiences of the care provided. We spoke with ten members of staff including the nominated individual, registered manager, deputy manager, senior care workers, care workers and the kitchen assistant. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with two visiting healthcare professionals. 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 ten people's care records and multiple medication records. We looked at two 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 quality assurance records. The registered manager implemented immediate systems to address the concerns found during the inspection.

Requires Improvement

Is the service safe?

Our findings

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

The last rating for this service was Inadequate. Since this rating was awarded the registered provider of the service has changed. This is the first inspection for this newly registered service. This key question has been rated 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People told us they did not feel safe living in their home. One person told us, "I don't feel safe because other people shout."
- People were not consistently protected from the risk of abuse. The provider's systems and processes were not fully embedded to protect people from potential abuse and to recognise and consider when safeguarding referrals needed to be made.
- One person had been subjected to emotional and verbal abuse. Although disciplinary procedures had been followed, the service had failed to recognise and follow procedures to safeguard vulnerable adults. As a result, a potential safeguarding concern had not been identified, reported or investigated by relevant external agencies.
- One person had been transferred from their lounge chair to a wheelchair inappropriately and without the use of specialist equipment that should be used to keep the person protected from the risk of harm.
- In response to our concerns both incidents were retrospectively reported to CQC and to the Local Authority.
- There were multiple safeguarding concerns being investigated at the time of our inspection.
- Although the staff we spoke with said they would report any concerns, some were unsure of how to report concerns to external bodies and were unsure about the whistle-blowing procedure.
- The service recorded incidents and accidents, however had failed to effectively monitor these. This meant that the service were unable to note trends that may be present in order to prevent comparable occurrences in the future.

People had not been protected from the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

Assessing risk, safety monitoring and management

- Risks were not always adequately assessed and mitigated to protect people from the risk of choking. One person's nutritional care plan stated they were at risk of choking and required thickened fluids. Despite staff knowing this risk and using thickened fluids, there was not a choking risk assessment or risk management plan in place to guide staff how best to support the person to keep them safe.
- People were not protected from the risks associated with skin damage. One person's care plan indicated they were at high risk of skin damage. To mitigate this risk the person required repositioning every two

hours. However, both feedback from staff and the records we reviewed were conflicting around the frequency of the repositioning. Some staff told us they did hourly checks, some said two hourly checks. We reviewed the repositioning chart for the person and found gaps at specific times. In addition, we found the length of the times the person was turned varied from two hours to five hours. This meant the person was at risk of further skin deterioration.

● People were not protected from the risks associated with malnutrition. We found that food and fluid monitoring charts had not always been completed fully. One person's care plan identified they were at high risk of malnutrition and had lost a significant amount of weight. There was no nutritional risk assessment in place to guide staff how to reduce the risks of malnutrition for the person. The person's nutritional intake was not quantified, and their fluid intake was not calculated on a daily basis to ensure their nutrition and fluid intake was adequate to maintain their health. Poor risk assessing meant that the staff we spoke with were not aware of the person's targets for food and fluid intake.

● During the inspection we observed a person walking around the communal lounge and picked up another person's prescribed medicine and drank it. CQC inspectors immediately intervened despite other staff being present in the lounge and not seeing it. Staff had not ensured medicines were kept safe.

● People were not protected from the risks associated with oral care. One person informed the inspection team that they were in pain with their mouth. The lead inspector brought this to the attention of the registered manager and requested medical advice was sought. Appropriate medicines were prescribed. We reviewed the person's oral care plan which indicated they were to be supported with cleaning their teeth on a daily basis. There was no record that the person had received oral care on 12 August 2019. Following the inspection, the registered manager advised that staff had offered oral care, but the person had refused, and staff had failed to record this.

● People were not protected from the risks of poor moving and handling practices. There were no risk management plans in place to guide staff how to use specialist equipment to help them to transfer safely. One person had been assessed by Community Occupational Therapy team
and were advised to use the hoist for all transfers. Despite this professional guidance and instruction, on 30 July 2019 and 02 August 2019 staff had attempted to manually lift the person. This may pose a risk to people's safety.

●The registered manager responded and acted upon all the above concerns both during and following the inspection.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care which placed people at risk of harm. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

●The provider maintained the safety of the building and equipment through regular checks, servicing and maintenance. Fire safety checks were completed. Personal evacuation plans were in place to ensure people received the right support in an emergency.

Staffing and recruitment

● People gave us mixed views on the staffing levels in the service. One person told us, "If I press that (buzzer) they will come. On average they take about 20 minutes, but they do come. It is better during the day than the night." Another person said, "They say they are busy. It can take up to an hour, sometimes they are quick, and it can take between 15 – 30 minutes."

●On the first day of our inspection we observed there were not enough care staff to meet people's needs as two people required the support of two staff to support them with behaviours that were extremely challenging. This had an impact on the staffing levels. The provider had a tool to assess the number of staff required, based on people's support needs. We saw staffing rotas reflected this. Following our inspection,

the Local Authority agreed to increase staffing levels to support two people until they had moved to alternative homes. At the time of publishing this report, people had been supported to new homes.

●The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal records checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Using medicines safely

●Senior care staff took responsibility for administering medicines and we observed they did this with patience and kindness. One person said, "I get my tablets on time every day."

● Systems to manage medicines were organised. However medicines were not always kept safe within communal areas. Staff were following safe protocols for the receipt and disposal of medicines.

● We reviewed the Medicine Administration Records (MAR) for people who were having prescribed topical creams applied to their body. We found that records of where the creams were being applied were not in place. We spoke with the registered manager who rectified this straight away. We reviewed the care records for people and saw that they had not experienced ill effects due to this issue.

● Although staff competency in relation to medicines was regularly checked, this had not been effective due to staff leaving medicines in unsafe places.

Preventing and controlling infection

●The home was predominantly clean on the day of the inspection and staff wore aprons and gloves to reduce the risk of infection. One person told us the environment was much cleaner. However, one relative told us, "Dad's room is never clean, especially weekends."

● The local authority told us that they had provided a lot of support to the home to improve their infection control processes.

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.

The last rating for this service was Inadequate. Since this rating was awarded the registered provider of the service has changed. This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People shared mixed views about food. One person told us, "The food is good, better than good some of it is. They do my favourites, faggots and peas. I enjoy the meals here." Other comments included, "The food here is rubbish." and "The food here is not for me."
- Some people told us they required a diet related to their cultural, ethical and religious needs. One person told us, "I eat food slowly. With roti I keep working on it until it is mushy and then I can swallow it but if it is hard, like today I leave it and just eat the dhal." A relative told us that the cultural food was, "Awful."
- We found mealtimes were not a positive and pleasant experience for people. There was little attention to the dining environment. One person told us, "They set the food down. They quickly take it away. They don't wait for me to finish." We observed food was not presented well. For example, at tea time people were served sandwiches, crisps and a cake all on the same plate.
- We observed staff placed meals in front of people without explaining what their meal was. People were not always shown the meal options on offer in a way that would help them to make a choice each day. This was not supportive of people living with dementia.
- People told us they were not involved in the planning of meals and records we sampled confirmed this.

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

- People told us they had access to healthcare professionals when required. One person said, "The GP from the local surgery has been in to see me. I have got high blood pressure."
- Care plans did not always contain important information and did not support staff to provide effective care. For example, people living with diabetes. This was addressed during the inspection.
- Health care professionals we spoke with gave varied feedback on the support staff offer to people to access healthcare input. One health professional raised concerns about the staff skills in maintaining people's health related to continence needs and told us they were not confident that staff had followed the instructions they had given to keep people healthy. These concerns had been raised with the local authority safeguarding team and were in the progress of being investigated.
- During the inspection we observed a person's urinal catheter bag was full. A member of the inspection team was required to alert staff members to empty the catheter bag. Failure to adequately support a full catheter bag put this person at risk of pressure damage. There was no catheter care plan in place to guide staff how to support the person with safe catheter care.

Adapting service, design, decoration to meet people's needs; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●People's needs were assessed prior to admission to make sure their needs could be met by the service. Some of these assessments did not include information about people's life history, culture, religion, sexual orientation and other preferences which would enable the service to deliver more personalised care.

● There was little for people to find to enable them to engage in independent activity such as accessing objects to occupy and stimulate, this would enhance the quality of life for those people living with dementia. There were some pictorial signs on doors to denote bathrooms and toilets.

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.

● We found decisions had been made about people's care without the correct steps being followed under the Mental Capacity Act (MCA). A best interest decision had been made for all people to not have the code for external doors. This included people who had the capacity to make their own decisions. Whilst no-one told us they wanted the code, this was restrictive practice. This was addressed immediately after the inspection.

●We saw staff stored people's walking frames away from them. Staff had failed to understand how it restricted people from moving as they wished. We brought this concern to the registered manager's attention who addressed this during the inspection.

● Staff told us they had completed MCA training. However, staff did not consistently gain consent from people. For example, staff were observed placing protective clothing on people without asking their consent or explaining what they were doing.

● The provider had submitted DoLS applications where they believed people could not consent to receive care and treatment at the home. None of these applications had yet been granted.

●Some of the staff we spoke with did not always know which people were subject to authorised DoLS. The registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS and how best to support them with their restriction, ensuring least restrictive practices were followed.

Staff support: induction, training, skills and experience

● People told us that in their opinion staff had the skills and right experience to meet their needs. One person told us, "They always seem to do their jobs."

●Staff told us that training was effective and gave them enough information to carry out their duties safely. A member of staff said, "We have regular training now, it's much better."

●Whilst the staff we spoke with told us they received dementia training, we found they did not always have the skills or time to work effectively with people living with dementia. There was no plan about how the

service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice. This meant that people were at risk of being supported by staff who may find it difficult to understand people's specific care needs.

●Care staff told us, and records showed that newly recruited staff undertook induction training when they first started to work for the service. This included the Care Certificate, which is a nationally recognised set of standards to ensure staff have the right skills, knowledge and behaviours.

● Care staff we spoke with told us that they felt supported in their roles and that the management team were approachable.

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.

The last rating for this service was Inadequate. Since this rating was awarded the registered provider of the service has changed. This is the first inspection for this newly registered service. This key question has been rated 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 gave us mixed views around how caring the support was that they received from care staff. One person said, "They (staff) are all friendly. I get on well with the cook. I get on well with most of them," Other comments included, "Some staff are good, some are bad. "and "New staff are great. Existing staff are stuck in their old ways, quite cold and not warm." One person told us they were unhappy with a staff member's attitude towards them. We brought this to the attention of the registered manager and immediate action was taken.

● We observed periods of the day where staff did not take time to talk or interact with people. For example, we saw very little conversation happening whilst staff were supporting people to eat. Staff sometimes missed opportunities to engage with people as they were focused on getting jobs done. One person told us, "I don't think they have time to chat." Another person said, "If you ask them they will do something but not otherwise."

● Some staff we spoke with understood people's needs based on their protected equality characteristics. One staff member told us, "I respect everyone's views on religions are different."

● Overall the service provided at Stanbrook Care Home was not caring and this could be demonstrated by the concerns found in the other areas of this report.

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

●People were not always involved in their care and support in a meaningful way. One person told us, "I have no-one to talk to." The registered manager told us that people were involved in planning their care. However, this was not always documented in their care plans.

● People were not always given the opportunity to make decisions. People were given meals and drinks without being asked what they wanted. One person said, "We can only have bacon and sausage on a Sunday." Another person told us, "With the food you don't get what you want, you have to put up with it because other people don't like what you like. I get my meals three times a day and two snacks a day. You have to live with it. I think I can have a choice except breakfast."

●We observed people being supported with their personal care needs at set times during the day and we saw people being offered drinks and snacks at set times also. One person told us, "I always say yes to tea and we have a cup of tea at 5pm."

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was not consistently respected and promoted. Although staff we spoke with

were aware of how to promote people's dignity, this had not been consistently practiced.

● Whilst staff told us they respected people's right to confidentiality this did not consistently happen in practice. We saw the staff handover being undertaken within the office with the door open that was within communal areas. Confidential and personal information pertaining to people was discussed and could be overheard by anyone who lived at the home and, or who visited.

●Staff used inappropriate and unacceptable language to describe people's care that did not promote their dignity. For example, one member of staff referred to people who required support to eat their meals as 'feeders'.

● We observed some staff having a conversation across the communal lounge about taking one person to the bathroom and had asked them to pull the buzzer when they had finished. This did not promote the person's privacy or dignity.

●One person told us, "I am used to having my shower on my own without any help. They help you. They are very good, and they have got big towels. They don't stare. They are respectful."

● Whilst we observed staff promoting people's independence with tasks such as promoting people's independence at meal times; we did not observe many opportunities for some people to take part in everyday living skills, for example, helping to set a table for lunch, or making themselves a drink if they wanted.

● People were supported to maintain important relationships. One person told us, "My children and grandchildren come and visit." One relative told us, "One of the family visit at least once a day, every day. There are no restrictions."

The lack of robust processes to ensure care was personalised, dignified and able to meet people's needs effectively demonstrated a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

The last rating for this service was Inadequate. Since this rating was awarded the registered provider of the service has changed. This is the first inspection for this newly registered service.This key question has been rated Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People did not always receive personalised support that met their needs. One person said, "They [the staff] are nice but they don't talk to me. It is all about their work." Another person told us, "There is a lot of bumping and banging of doors all night long. I don't sleep very well here. I come up here in the afternoon to have a nap instead."

●Care was not always responsive to people's needs. One person told us, "Some of them (staff) come when I need to go to the toilet, some don't."

● People told us they were offered limited choices for breakfast. One person told us, "They give me cornflakes. I say yes, I will eat them, but it doesn't mean I want them all the time. I would like bacon, sausages and eggs. I would like boiled eggs for breakfast, something like that."

● People's care plans were reviewed regularly, but these reviews were not meaningful. There was no evidence that people had been actively encouraged to be involved in discussing or reviewing their own care on a regular basis. This meant there was little evidence that people had any choice or control over their own support.

● People's pastoral care needs were not consistently met. One person told us, "There is no one to take me to the mosque."

● People appeared unstimulated, on day one of the inspection no formal leisure opportunities occurred for people. One person told us, "I sit out here and smoke. There is nothing else to do here." Another person told us, "I've lost all my social life. I used to have my hair done every Saturday and I would go out for a coffee with my friends." A relative said, "Never see activities, people just sit with TV on." We saw staff trying to engage people in some activities during the inspection, such as nail painting and board games but there was no evidence that people had been consulted about what activities they would like or reflected their interests.

● During day two of the inspection an external activity person visited the home and during these times it was apparent people were more stimulated and enjoyed themselves.

● People were not consistently encouraged to access and integrate with the local community with support from staff to reduce social isolation. People and staff told us there were no regular or planned trips out. Four people told us how unhappy they were. One person told us, "I'm passing time, I am existing here. There is no living here."

●There were no leisure opportunities or protected time in place to support people who lived in their rooms to help to prevent social isolation.

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.

● Information was not always presented in ways that were accessible. For example, the daily menu was presented in picture format but was so small for people to see. This meant that people did not always have access to information they needed.

●We saw the provider had not ensured people were communicated with in an effective way that maximised their independence and enabled them to be fully involved around choices about their day to day care and activities. While we saw Punjabi speaking staff were available within the staff to assist with communication for Punjabi speaking people; we saw the communication needs of others had not been considered. For example; two other people spoke other languages and their communication needs had not been considered.

●The registered manager told us picture cards were available. However, we did not see these being used during the inspection.

● Care plans had been designed electronically. There had been no consideration to design care plans in a way that meant people who lived at the home would be able to understand and comment on their contents.

End of life care and support

● People could not be confident that their wishes during their final days and following death would be understood and followed by staff. Some people's care plans identified they had strong faith and religious needs and may have had specific end of life wishes. The service had not explored people's preferences, choices, cultural or spiritual needs in relation to their end of life care.

The lack of robust processes to ensure care was personalised and able to meet people's needs effectively demonstrated a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People told us they knew how to complain if they wanted to. Most people told us they would speak with the manager or a member of staff if needed. One person said, "I would tell any of the girls [the staff]." However, a relative told us when they complain, it's not listened to and said, "It gets better then goes right back to what it was."

● The service had logged two recent complaints. In each case there was a timely response and complainant's were happy with the outcome.

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.

The last rating for this service was Inadequate. Since this rating was awarded the registered provider of the service has changed. This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● People's health and well-being was not sufficiently protected. Governance systems to monitor the safety of the service were inadequate. The systems in place had not ensured people received the care and support they needed. Risks were not always adequately assessed and mitigated to protect people from the risk of choking. People were not protected from the risks associated with skin damage. People were not protected from the risks associated with malnutrition. We found that food and fluid monitoring charts had not always been completed fully.

● Staff had not ensured medicines were kept safe. People were not protected from the risks associated with oral care. People were not protected from the risks of poor moving and handling practices. There were no risk management plans in place to guide staff how to use specialist equipment to help them to transfer safely. Neither had it always been identified that people were not being supported in accordance with external health care guidance.

●There were no systems in place to show that learning from accidents and incidents had taken place or how the information gathered had been used to prevent or reduce the likelihood of a reoccurrence.

●The registered provider's systems and processes were not fully embedded to protect people from potential abuse and to recognise and consider when safeguarding referrals needed to be made. As a result, potential safeguarding concerns had not been reported to the relevant safeguarding agencies and CQC.

●There were no effective systems in place to check the competency of care staff to ensure they were equipped with the skills needed and were applying their learning into practice.

● Governance and oversight systems had failed to ensure the registered provider was working consistently in line with the principles of the Mental Capacity Act (2005). Some best interest decisions were carried out where people had the capacity to make decisions.

● The quality audit system for the environment and the prevention of infection was ineffective. The most recent audit in August 2019 identified all bedrooms had been checked and no action was identified. However, we found one person's bedroom to be offensive smelling.

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

● People told us they knew who the registered manager was and most felt they were approachable. One person told us, "I get on well with the manager." A relative said, "[name of manager] is great and has made some improvements compared to the last provider."

● However, the provider failed to have effective systems in place to ensure that people received person centred care that was appropriate to their needs and were given choice and control over how they preferred to spend their days.
● People told us, and records corroborated that they were not involved with the planning and reviewing of care plans.
●There were no quality assurance systems in place to consider the impact of not adapting the information to enable person-centred care to enable people to communicate effectively.
●The registered manager and provider had not identified the concerns we have found with regard to the mealtime experience and outcomes for people.
● The registered provider had failed to ensure people received person-centred, dignified and respectful high-quality care and good outcomes for people. There was a culture of task-centred instead of person-centred care. There were no effective systems in place to ensure that people were given choice and control over how they preferred to spend their days.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This constituted a breach of Regulation 17 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 registered provider was present during our visit and we shared our inspection findings with them. They were unable to explain why their governance systems had failed to identify the significant short falls we had found. Following our visits, we requested and received information which assured us action was being taken to mitigate the risks we had identified for people.
●The provider had a duty of candour policy in place and they were aware of their responsibilities to be open and transparent when things went wrong.
● The registered manager and provider were receptive to feedback and proactive in making improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Whilst there were systems in place to involve people in service improvement, people's views about the quality of care they received had not been sought effectively. One person told us, "The list is too long to change things like more light in my room. The room is always dark. I have to use the lights day and night." People had not been empowered to make suggestions that would improve their quality of life and had not been given the opportunity to shape and improve the service.
●The provider's values of wellness, compassion and kindness were not always implemented in practice. Staff were not consistently observed sharing friendly interactions with people, respecting their choices, equality and diversity as well as their right to make decisions.
● Staff told us they had opportunities to attend meetings with the manager to discuss the service and raise any issues. A staff member said, "[Name of manager] is fair and does listen to us."

Continuous learning and improving care; Working in partnership with others
● Adequate provider oversight to drive improvement was ineffective. The quality assurance systems were limited in their effectiveness to ensure continuous improvement. Despite carrying out regular audits, including those completed by the registered manager, the standard of care people received was poor.
● The service worked closely with the local authority quality team and health professionals as they carried out regular visits to the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences. Regulation 9 (1) (3)(a)

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm due to poor risk management processes within the service. Regulation 12 (2) (a) (h)

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected by harm due to a failure to identify, report and manage safeguarding incidents. Regulation 13 (1) (2) (3)

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. Regulation 17 (1) (2)(a)(b)

The enforcement action we took:

We have taken enforcement action to impose conditions on the registered provider's registration.