HC-One Oval Limited

Gallions View Care Home

Inspection report

20 Pier Way
London
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: The home is registered to provide nursing and personal care support for up to 60 older people. At the time of our inspection 40 people were receiving personal care and support from this service across two units.

People's experience of using this service:
•Care plans and risk assessments were not always updated to reflect changes in people's care needs.
•Risks to people were not always identified and risk management plans were not in place to manage risks safely.
•Monitoring charts, including close observation charts, elimination charts and food and fluid charts were not always completed to help ensure people's safety.
•People's medicines were not always safely managed.
•Incidents were not appropriately logged or investigated to reduce the risk of repeat occurrences.

•Staff were not effectively deployed and were not always aware of their responsibilities. Staff training was not up to date and staff were not always supported through supervisions to ensure they carried out their roles effectively.

•The provider had not followed safe recruitment practices when recruiting new staff.
•People were not always supported and encouraged to eat a healthy and well-balanced diet
•People and their relatives told us and we saw staff were not always kind and did not always respect their privacy, dignity or promote their independence.

•People were not involved in planning their care and support needs.
•People who could not communicate were not provided with information in a format that met their needs.

•The provider's quality monitoring systems were not effective.
•The registered manager had a lack an understanding of their regulatory responsibilities as they had not reported incidents to the local authority safeguarding team or CQC where required.
•People and staff commented that the registered manager was not visible and did not provide adequate leadership and support.
•People told us they felt safe. There were appropriate adult safeguarding procedures in place to protect people from the risk of abuse.
•People were protected from the risk of infection because staff followed appropriate infection control protocols.
•Assessments were carried out prior to people joining the service to ensure their needs could be met.
•People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
•People had access to healthcare professionals when required to maintain good health.
•People were provided with information about the service when they joined in the form of a 'service user

guide' so they were aware of the services and facilities on offer.
•People were aware of the provider's complaints procedures and knew how to raise a complaint.
•The service was not currently supporting people who were considered end of life but the provider was aware of best practice in this area.
•The provider worked in partnership with the local authority to ensure plans were in place to meet people's.

Rating at last inspection: Inadequate (report published 19 February 2019).

Why we inspected: This inspection was a responsive inspection to follow up concerns we had received about the service.

Enforcement: We found breaches of Regulations in relation to safe care and treatment, person centred care, dignity and respect, staffing, recruitment, good governance and notifications. The majority of which were continued breaches from our previous inspection.

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

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority. The overall rating for this registered provider is 'Inadequate' and the service therefore remains in 'Special Measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

Details are in our Effective findings.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Caring findings.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings.

Gallions View 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 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The team consisted of two inspectors, one specialist nursing advisor, and an expert by experience. The expert by experience is a person who has personal experience of caring for an older person living with dementia.

Service and service type: Gallions View is a care home that provides nursing and personal care and support for up to 60 older people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection: This inspection site visit took place on 9 and 10 April 2019 and was unannounced.

What we did: Before the inspection we reviewed information, we had received about the service in the time since our last inspection. This included details about incidents the provider must notify us about, such as allegations of abuse, and serious accidents and incidents. We sought feedback from the local authorities who commission services from the provider, and from professionals who work with the service. Usually the provider is asked to complete a provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, on this occasion the provider was not asked to complete a return as we brought the inspection forward due to the concerns we had identified in our monitoring of the service.

During the inspection: We were only able to speak with three people either because other people were

unable to communicate with us verbally. 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 also spoke with four relatives to ask their views about the service. We spoke with six members of staff, the registered manager, quality manager and the area manager. We reviewed records, including the care records of 12 people using the service, recruitment files and training records for three staff members. We also looked at records related to the management of the service such as quality audits, accident and incident records, and policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

Inadequate: People were not safe and protected from the risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management.
•At our last inspection we found that risk management plans did not always provide appropriate guidance for staff about how to minimise risks and staff did not always follow guidance that was in place to safely minimise risks to people. We found that information regarding people and their current needs was not always adequately shared between each shift to ensure they received safe support, and monitoring charts had not always been completed as required. Medicines were not managed safely and incidents were not always logged and investigated appropriately. An action plan had been submitted following the last inspection to address these concerns.
•At this inspection we found that the action plan had not been met and no action had been taken to address the concerns.
•We found risks relating to people's care and support were not always managed safely. Risks to people had been assessed in areas including medicines, mobility, the environment and nutrition. However, there were not always updated risk assessments and risk management plans in place for staff to follow to minimise the risk of falls. For example, one person suffered a fall on 9 March 2019 but their risk assessment and care plan had not been updated at that time or during a subsequent falls care plan review on 31 March 2019. The same person suffered another fall on 8 April 2019 and again their risk assessment and care plan had not been updated to reflect any changes in their care and support needs.
•On the first day of inspection we observed a staff member giving one person a hot mug of tea whilst sat in their wheelchair. The person then tried to drink the tea with one hand, whilst trying to mobilise the wheelchair with the other and went on to put the hot mug of tea between their legs before mobilising in their wheelchair to their room. This placed the person at serious risk of scalding and staff confirmed that the person did this regularly because they wished to remain as independent as possible. However, both staff and the registered manager confirmed that the person did not have a risk assessment in place to help ensure the risks of the person's actions had been full considered and minimised whilst enabling them to maintain their independence. This put them at increased risk of avoidable harm.

•One person's care plan dated 1 April 2019, stated that adjustments had been made to their diet to help manage an increased risk of them choking following their recent discharge from hospital. The care plan included advice from a Speech and Language therapist (SALT) on how to reduce the risk of aspiration (inhaling food or saliva into the lungs) and stated that they required a pureed diet. SALT guidance also documented that the person needed to be supervised when eating and drinking. However, the care plan did not record that the person was on a pureed diet. This meant there was a risk of the person receiving unsafe care and increasing their risk of choking. This person's care plan also did not record that the person was a diabetic on insulin.

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

•We found people's supplementary charts were still not being completed as required. The charts included close observation charts to ensure that the needs of those being nursed in bed were being met, and elimination charts to show people had been assisted with their incontinence needs. One person was being nursed in bed and was unable to use their call bell, so required hourly checks by staff. However, records showed that on 31 March 2019 they had been checked at 10.03am and then no further checks were carried out until 8.40pm. On 1 April 2019, the person was checked at 9.45am and then no other observation checks were carried out until 7pm. On 2 April 2019, the person was checked at 9.30am then no observation checks were carried out until the following day, 4 April 2019 at 10pm. This meant the provider was unable to demonstrate that regular checks had taken place to help ensure this person's safety and well-being.
•A second person was nursed in bed, unable to use a call bell and required hourly observations Their close observation charts between 25 March 2019 and 28 March 2019 showed that they were not completed every hour as required .
•We saw one person's elimination charts showed that their incontinence pads had not been changed regularly between 25 March 2019 and 31 March 2019. Therefore there was a risk that this person's needs had not been met and that staff were not taking appropriate action to prevent avoidable harm.
•Staff told us that they did not always have enough time to complete monitoring charts as they had too much to do. The registered manager and area manager were unable to say why monitoring charts continued not being completed.

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

Using medicines safely.
•Medicines were not safely managed. One person's care plan gave staff information about the management of their diabetes and the associated risks of high or low blood sugar. However, the care plan was dated 9 December 2018 and had not been updated when the person had been admitted to hospital on 8 March 2019 for a serious condition to reflect the change in the dose of insulin they required.

•The same person was discharged from hospital on 21 March 2019 and their care plan was reviewed on 27/3/2019, however, the care plan had not been updated to inform staff that the person had experienced low blood sugar which had led to a hospital admission and how to manage this to ensure the person's wellbeing.
•On the first day of the inspection we found that the care plan for one person had not been followed nor the instructions on the Medicine Administration Record (MAR) chart for the administration of Insulin. Insulin was prescribed twice a day and in the morning the instruction was to administer the insulin before breakfast to manage the person's blood sugar levels. We observed staff administering insulin to the person after breakfast. The administering staff member did not record the time of administration nor the reason for the late administration. We brought this to the nurse's attention who told us that the person's blood sugar monitoring identified low blood sugar and they needed breakfast before the insulin was administered. This meant that staff did not follow prescribed administering instructions. This also meant that staff and any healthcare practitioners managing and monitoring the person's diabetes would not have an accurate picture of the diabetic care given to the person because records completed in relation to blood sugar levels were not accurate.
•MAR charts for topical creams had not been completed, so we could not establish if medicines had been administered to people in line with the prescriber's instructions. One person's MAR chart for a topical cream did not detail how often the medicine should be administered. The prescription label was too worn to detail

administering instructions. Between 25 March 2019 and 9 April 2019, records showed MARs were not completed in full so it could not be established whether medicines had been administered or not. If medicines had not been administered, there were no details to explain why the medicines were not administered.
•Another person's MAR chart for a topical cream recorded that it needed to be applied all over the body, but it did not detail how often the cream needed to be applied. The prescription label was too worn to read administering instructions. Between 25 March 2019 and 9 April 2019, records showed that the cream was administered on 11 occasions in the morning and there were 5 mornings when the cream was not administered. There were no reasons recorded as to why it had not been administered. There were no records to show that it had been administered at lunch-time or the reasons why it had not been administered. It had only been administered once on 2 April 2019 at dinner-time and there were no records to show that it had been administered at night-time. There were no details of why the cream was not administered on the occasions that the MAR chart was not completed.

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

Staffing and recruitment.
•At the last inspection we found that there were not enough staff to meet people's needs in a timely manner.

•At this inspection, there were enough staff to meet people's needs. However, they were not effectively deployed in a way which meant people were consistently supported in a timely manner to keep them safe. There was no management oversight of the deployment of staff to ensure they were carrying out tasks as required and meeting people's needs effectively.
•Staffing rotas confirmed that on both days of the inspection, both units had a full complement of staff. However, staff said they did not feel there were enough staff to manage the high dependency needs of the people currently living in the home.
•Care staff were not always available in the lounges and activities coordinators were left supervising people in the lounge areas until care staff became available. Care staff confirmed this was because there were not enough care staff.
•Staff also told us that they did not always have time to complete supplementary charts as they had too much to do.
•We saw staff huddled around the lunch trolley instead of spending time engaging with people and ensuring that their needs were met at lunchtime. We also saw that the activities coordinators were required to assist people with lunch as staff claimed there were not enough staff to support everyone who required assistance with their meal. We also saw activities coordinators serving beverages. The use of activities coordinators to carry out care tasks meant they were not able to concentrate on delivering meaningful activities. This had not improved since the last inspection.
•The registered manager told us that staffing levels were based on an assessment of people's needs. However, when asked they were unable to provide us with any details of the way in which people's needs had been assessed after receiving staff feedback that there were not enough staff to meet people's high dependency needs in a timely manner. There was also no clinical lead or oversight by management.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Recruitment checks were not robust. Although staff files contained proof of identity, and criminal record checks had been undertaken for each staff member, application forms were not completed in full as there

were unexplained gaps in employment histories for three new staff members. One staff member's application form had an unexplained gap in employment between 5 December 2017 and 18 March 2018. Another staff members' application form dated 15 November 2018 did not have any information about their employment history since 2016. A third staff member's application form had an unexplained employment gap between 19 April 2017 and 7 November 2018. These gaps had not been explored to ensure that staff were suitable to work with people at the service.
•Reference checks were not robust, one staff member had two references from the same person at the same address and this had not been identified and followed up.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong.
•At the last inspection we found that incidents were not always logged and investigated appropriately when they occurred in order to ensure people's safety was maintained.
•At this inspection we found improvements had not been made as incidents were still not logged and investigated appropriately. On 25 March 2019, one person was prescribed antibiotics by the GP at 12.30pm. The GP returned to the surgery and faxed the prescription to the local chemist but the medicines were not delivered. At 8pm the person still had not been administered the antibiotics as they had not been collected by staff from the chemist. At 0.45am, staff monitoring the person discovered they had a high temperature. At 1.30am, the person's condition deteriorated, and an ambulance was called. The person was given intravenous antibiotics for a lower respiratory tract infection and treated for dehydration at the hospital. On the first day of inspection the person's relative told inspectors that the registered manager had not fully investigated this incident. We saw there were no records to show that this incident was investigated by the registered manager, or to demonstrate that lessons had been learnt and learning shared with staff to reduce the risk of repeat occurrence.

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

Systems and processes to safeguard people from the risk of abuse.
•There were appropriate systems in place to safeguard people from the risk of abuse. Staff had received appropriate training and knew of the types of abuse and what to look out for and whom to report their concerns to. However, the management team had not always reported safeguarding concerns to CQC and other agencies as required.
•People and their relatives told us that they felt safe. One person said, "I feel safe and comfortable." One relative said, "My relative is safe."

Preventing and controlling infection
•People were protected against the risk of infection. There were policies and procedures in place and staff were provided with appropriate guidance.
•Both care and kitchen staff had access to personal protective equipment (PPE) which included aprons and gloves. We observed staff using PPE when needed during our inspection Staff also confidently described how they prevented the risk of the spread of infections, by wearing aprons and gloves and washing their hands to prevent the risk of infection.
•One person told us, "Yes staff wear aprons when they help me."
•The home was clean and tidy and the kitchen was clean, organised and food in the fridge was stored correctly.

Requires Improvement

Is the service effective?

Our findings

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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Two regulations were not met.

Staff support: induction, training, skills and experience
•At the last inspection we found that staff training was not up to date and staff were not always supported through regular supervisions. This meant the provider could not be assured that staff had the knowledge and skills to carry out their roles competently.
•At this inspection we found that no action had been taken to address the concerns found at the last inspection and the action plan submitted following the last inspection to address these concerns had not be met. Records confirmed that not all staff had completed mandatory or refresher training.
•Some staff told us that they had not received up to date fire training which included physical fire drill training from the provider. Fire training records showed that 65% had received physical fire drill training, records did not confirm how many staff had received general fire training. The home's two fire marshalls told us that they had not received Fire Marshall (Chubb) training from some years and had not received it from the current provider. Both fire marshalls confirmed that they had not received physical fire training in relation to evacuation mats that were available and therefore were still using the old provider's evacuation mats that were different. This meant that staff were not competently trained and this was a risk to people's safety.
•Training completed for safeguarding adults was 82.5%. Moving and handling training was 78.5%. Infection control training was 81%. Equality and diversity training was 84% and records available did not confirm how many staff had up to date medicines training. This meant the provider could not be assured that staff were skilled and experienced enough to carry out their roles competently.

•Records for staff supervisions were not provided during the course of the inspection. Following the inspection, the area manager sent us information about supervisions undertaken, however we were not able to establish that all staff had received regular supervisions and annual appraisals in line with the provider's policy.

This was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
•People were not always supported to eat and drink enough to maintain a balanced diet.
•At the last inspection we found that that there were no pictorial menus in the dining room to help support people to choose their meals. People were not always supported to eat their meal.
•At this inspection we saw that there was a monthly menu in place, however there were still no pictorial menus to help support people in choosing their meals.

•People were not always supported to eat meals. For example, we saw one person fall asleep both before and after their food was placed in front of them. No staff spoke to them to tell them that their lunch was ready or to encourage them to eat. The food was left untouched for 20 minutes and went cold. A staff member then took the plate away without encouraging or trying to support the person to eat.

•One person who was vegetarian was given fish. We checked the handover sheet for the day and saw that it recorded that the person was on a normal diet. This meant staff did not know about people's individual nutritional needs.
•Another vegetarian person was given jacket potatoes two days in a row without being offered any alternative when they did not want the potato.
•The majority of people at the home live with dementia. We saw that only one unit physically showed people the two meal options on offer so they could choose what to eat on the day. On the other unit meals were just placed in front of people. People were not always shown the meal options on offer in a way that would help them to make a choice each day.
•We observed one activities coordinator carrying out a dining audit at the same time as supporting a person to eat. They also got up and left the person to assist another person by getting a cushion for their head. This meant that people were at risk of not eating and drinking enough when staff supporting them were carrying out more than one task at a time and this was not respectful.

•People's food and fluid charts were not completed in full so that their intake could be monitored to identify if they were at risk of malnutrition or dehydration. For example, one person only had one food chart available, this was dated 10 April 2019. This chart was not completed in full, there were no records about how much the person's food and fluid daily intake totals should be and whether or not the person was meeting this target. The person's care plan also did not detail why the person's food and fluid was being monitored. This placed the person at risk of malnutrition and dehydration as staff were not aware of how much the person was drinking. This also meant that accurate information could not be provided to health care professionals about the persons food and fluid intake if further action needed to be taken.

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

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

•The registered manager and staff had a good understanding of the MCA and DoLS. They told us if they had any concerns regarding any person's ability to make decisions they would work with the person using the service, their relatives, if appropriate, and any relevant health care professionals to ensure appropriate capacity assessments were undertaken. If the person did not have the capacity to make decisions about

their care, their family members and health and social care professionals would be involved in making decisions for them in their 'best interests' in line with the Mental Capacity Act 2005.
•The registered manager worked with the local authority to ensure the appropriate assessments were undertaken. Where applications under DoLS had been authorised, we found that the provider was complying with the conditions applied on the authorisations.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
•Assessments of people's needs were carried out prior to them joining the home. This was done to ensure the home would be able to meet people's care and support needs.
•Initial assessments included people's medical, physical and social needs; personal care, medicines, eating and drinking and continence care. They also included information about the level of support people required.
•These assessments, along with referral information from the local authority that commissioned the service were used to produce individual care plans so that staff had the appropriate information to meet people's individual needs effectively.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care.
•Staff worked in partnership with health and social care professionals to meet people's needs. This included working with GPs, speech and language therapists and district nurses.
•People's healthcare appointments were kept in their care files and their health was monitored. If staff had any concerns about people's conditions records showed that the home referred them to health and social care professionals when required. One relative said, "The GP came and referred my relative to have physiotherapy."

Adapting service, design, decoration to meet people's needs.
•The majority of people at the home were living with dementia and as such the provider had sought to make some areas of the environment dementia friendly, for example using memory boxes outside of people's bedrooms. Bedroom doors were painted different colours to help people identify their rooms and there was appropriate signage in place to help people orientate themselves easily.

Inadequate

Is the service caring?

Our findings

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

Inadequate: People were not always supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity.
•At the last inspection we found that staff were not always caring and kind. There was little interaction between staff and people. Staff were not always attentive and did not verbally communicate with people or make eye contact.
•At this inspection we found that that no action had been taken to address the issues found at the last inspection. We observed that staff were not attentive and there was very little or no interaction between staff and people.
•Staff were seen standing or walking around the lounge area without speaking to people.

•Relatives told us that staff were not always kind and caring. One relative said, "Staff don't always listen. Sometimes, they walk out when my relative is talking mid-sentence. Some staff are good, some are not." Another relative said, "Staff appear to listen but then don't act."

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

•People were given information in the form of a 'service user guide' prior to joining. This guide detailed the standard of care people could expect and the services provided. The service user guide also included the complaints policy, so people were aware of the complaints procedure should they wish to make a complaint.
•People's information was stored securely in locked cabinets in the office and electronically stored on the provider's computer system. Only authorised staff had access to people's care files and electronic records.
•The service recorded people's religious beliefs, cultural or spiritual needs. This included people's faith and cultural meals that they liked to ensure people's needs were met.

Respecting and promoting people's privacy, dignity and independence.
•At this inspection we found that staff were not always caring and people's privacy, dignity and independence was not always respected. •A

•On the first day of our inspection we observed the activities coordinator asking a staff member to address an issue with one person's clothing to help ensure their dignity was maintained, but the staff member failed to act to address the issue appropriately, saying it was too late.
•We saw both care staff and domestic staff knocked on people's doors and entered without waiting for a reply. For example, one member of care staff knocked on a person's bedroom door to retrieve some paper

work for the inspection team. They failed to wait for a reply before entering, they also left the bedroom door open whilst the person received personal care.

•We saw that there was little or no staff interaction with people throughout our inspection, including the lunchtime period. Staff just stood in the lounge area and staff did not always explain to people what they were having for lunch and instead just put plates in front of them. Staff congregated around the lunch trolley instead of supervising people and speaking with them.

•Staff did not explain to people what they were going to do before supporting them. For example, one person was sat in their wheelchair and staff started to mobilise them without warning and checking that their feet were on the foot rests. The person had recently suffered a foot injury and the action of staff resulted in them shouting out in pain and asking them to be careful of their foot. The staff member failed to apologise and continued the task without interacting with the person or ensuring they were safe.

•We did not see people being encouraged to be independent in relation to eating and drinking. Staff put meals in front of people who were able to eat independently. If they did not eat staff did not encourage them to independently eat or ask if the food was to their liking or whether they wanted an alternative or support to eat.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care.
•People were involved in making decisions about their daily needs and level of support. For example, what time they wanted to get up or what they wanted to wear.
•Staff knew how to support people; they understood and were able to describe the individual needs of people who used the service. For example, one staff member said, "One person does not like bread, so I make sure that they are not offered it."

Inadequate

Is the service responsive?

Our findings

Responsive – this means that the service met people's needs.

Inadequate: People's needs were not always met. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

•At the last inspection we found that there was a lack of meaningful activities on offer to people using the service. There was one activities coordinator who split their day between the two units, but who was also required to support care staff in serving teas and coffees, assisting people to eat at lunch-times and supervising people until care staff were able to do so. People who were unable to communicate were not provided with information in formats that they could easily understand. People continued not be involved in reviewing the care and support needs and people's end of life wishes continued not be recorded in their care plans.
•At this inspection we found that although the home now had three activities coordinators, one full-time and two part-time, there was still a lack of meaningful activities on offer to people. This meant that people were at risk of social isolation and not having their social and leisure needs met in a meaningful way that enabled them to fully participate in daily life.
•We observed activities coordinators still serving drinks, supporting people to eat at lunchtime and supervising people in the lounges until care staff became available to do so instead of engaging people in either individual or group activities.
•We saw and were told by relatives that people living with dementia were not offered stimulating activities on a regular basis.
•We saw people were still placed in front of the TV to keep them entertained. Staff and relatives told us this continued to be a daily occurrence. Some people continued to be socially isolated with little or no stimulation because they were cared for in bed and could not leave their rooms. One person, who was cared for in bed and spoke no English continued to be supported by their spouse to keep them company on a daily basis. Since the last inspection, we saw that their activity record had not been updated to show if they had engaged in any activities. There continued to no management oversight in relation to activities.

•The same person's care plan recorded that they enjoyed having their legs massaged, however there were no records to show that they were engaged in this activity. Staff told us that this person was never engaged in this activity.

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

•At the last inspection we found that the provider was not meeting the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand, so that they can communicate effectively. There were a number of people at the home that required support to communicate, however the

registered manager or staff were unable to tell us what formats information had been made available in to meet people's needs. There was one person who had a language barrier and could not speak any English, however, information had not been provided to them in the language of their choice. There were no records to show that providing information in the person's language had been explored. No pictorial tools were available to the person to support them to make staff aware of their choices and preferences.

•At this inspection we found that no improvements had been made and information was still not available in formats that met people's individual needs. We found that the person who could not speak English, still did not have information available in their first language and pictorial tools were not used to help staff effectively communicate with the person.

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

•People and their relatives were not involved in planning their care needs.
•Care plans were not always regularly reviewed and updated to ensure they reflected people's current needs and contained accurate information about their health and wellbeing. We found recording gaps in relation to body maps, observation, elimination and food and fluid charts.
•One person's care plan reviewed on 27 March 2019 stated they were 'Able to communicate their needs.' However, when this person had been discharged from hospital on 21 March 2019, the discharge summary clearly stated that they 'Cannot communicate verbally.' This was confirmed by a staff member who was assisting the person on the first day of our inspection. Therefore, the person's risk assessments and care plan had not been updated to reflect the change in their needs following a hospital admission and during a care plan review that took place six days after their discharge from hospital.
•Care plans continued to not always have individual risk assessments or guidance for staff on how to mitigate and manage these risks and therefore we could not be assured that people's needs were always met.

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

•People's care files had a personal profile in place, which provided information about the person such as date of birth, gender, ethnicity, religion, medical conditions, next of kin and family details and contact information for healthcare specialists.
•Care files included individual care plans addressing a range of needs such as medicines, communication, moving and handing, nutrition, and physical needs.

End of life care and support.
•At the last inspection we found that people's end of life wishes were not always recorded in their care files when required. The registered manager had not always recorded what was important to people if they were approaching end of life. This included people they wanted informed and their preferences and choices about their end of life.
•At this inspection we found improvements had not been made and people's end of life wishes continued not be recorded in their care files when required. This included details of the people or relatives they wanted informed as well as information regarding their preferences and choices about their end of life.

This is 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.
•At the last inspection we found that complaints were not adequately logged and investigated. At this inspection we found that the provider had a system in place to handle complaints effectively. The service had investigated and resolved complaints received within timeframes set in the provider's complaints procedure.
•People told us that they knew how to make a complaint if they needed to. One person said, "I made a complaint to the manager and they dealt with it."

Inadequate

Is the service well-led?

Our findings

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

Inadequate: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

•At the last inspection we found that the systems in place to monitor the quality of the service were not effective. The provider had either not identified the issues we found during that inspection or had not promptly acted to address the issues they had identified. This included medicines not being safely managed, staff training not being up to date, lack of meaningful activities being offered to people. The provider did not have oversight of staff and the home, staff felt they were not listened to and staff morale was low.
•At this inspection we found that the provider had failed to make improvements and failed to meet the action plan they submitted after the last inspection to ensure all future audits would be robust. Systems to monitor the quality of the service remained ineffective and failed to identify issues we found at this inspection in relation to medicines, care plans and risk assessments, supplementary charts, incidents, staffing, activities, and people's privacy and dignity being respected. For example, care plan audits failed to identify that supplementary charts were still not being completed and medicine audits did not identify that topical cream Medicine Administration Records (MARs) were not always being completed. Staff training continued not to be up to date and meaningful activities were still not being delivered to people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
•The governance of the service was not effective or robust and this was evidenced by the poor standards of care we found.
•The extensive nature of the breaches of the Regulations we have identified and the impact of these demonstrated a failure of leadership and governance at the home at registered manager and provider level.
•Standards of care at the home had declined considerably since our last inspection. The provider was not aware of the majority of the concerns we raised during the inspection.
•Staff continued to feel that management did not listen to their concerns in terms of staffing. Staff continued to feel that there was a continued lack of leadership at the home and staff morale was low.
•Staff and people told us that the registered manager and deputy manager rarely visited the units and the only reason they were on the units was because there was an inspection. One staff member said, "There is no leadership. Nothing has changed since the last inspection. The registered and deputy managers do not communicate with staff." Another staff member said, "The registered manager is not supportive and there is not an open and transparent culture." One person told us, "I don't know the manager.". A relative said, " I've never seen the manager, they don't walk around and speak to residents and families." Another relative said, "The manager and deputy manager are not good. They are not up to the responsibility they have got."

•People's care and support needs were not regularly reviewed to ensure their needs were met.

•The management team did not understand their responsibility to be open and honest and did not take responsibility when things went wrong. For example, when one person ended up in hospital after staff failed to pick up medicines that had been prescribed by their GP. On the first day of inspection the relative of the person told us that they had requested information around this failing but information was not forth coming from the registered manager.

Continuous learning and improving care
•Records demonstrated that audits were carried out, however, they were not effective as they did not identify the issues we found at this inspection. This meant that these matters were not being addressed in order to improve the quality of the service. Significant improvements were required following our previous inspection, however, the provider has failed to address the issues raised to improve the quality of care and there was no evidence of learning to achieve and sustain the required improvements. There was no evidence to suggest that events and incidents were explored and analysed to identify trends and patterns and address these.

The above issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•At the last inspection we found that learning was not disseminated to staff from incidents, accidents and errors.
•At this inspection we found that regular staff meetings were held. Minutes from the meeting held in February 2019 showed areas discussed included complaints, incidents, communication, that the registered manager and the deputy manager failed to spend time on the units and that both units were not fully staffed. However, we did not see any action plan to address this feedback and drive improvements and staff told us improvements relating to management support and staffing had not been made. There were no records to demonstrate that learning was disseminated to staff from incidents, accidents and errors.

•One relative said, "I have been to a couple of residents' meetings. I have given suggestions, they seem to agree with what I say but don't do anything about it."
•An annual survey to obtain people's feedback about the service was carried out in May 2018. Although people's feedback had been negative about there not being adequate communication between the registered manager and people there was no action plan in place to address the issues they had raised or to drive improvements.
•Regular residents' meetings were held and we saw the meeting minutes. Areas covered in the meeting held in January 2019 included staffing and activities. We saw that people said that there were not enough staff as they all went on break at the same time. We did not see any action plan to address this feedback and drive improvements.

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

•The philosophy of the home was to provide people with the highest standard of individualised care where people's rights, habits, values and cultural background are safeguarded and respected. Staff told us that the home did not deliver this. Our observations confirmed this as the provider was not always delivering person-centred care.
•The service had a registered manager in post. We saw the current inspection rating for the service was clearly displayed. However, the registered manager had a lack of understanding of their regulatory

responsibilities. This was because they had again failed to report incidents at the home as being potential incidents of abuse amounting to a breach of regulations. For example, the registered manager had not informed the local authority or CQC of the incident regarding the failure to obtain medicines from the pharmacy after the GP prescribed them when they were aware that the medicines needed to be collected from the pharmacy as they did not deliver medicines to the home. Subsequently the person had been admitted to hospital.

This was a breach of Regulation 18 of the Care Quality (Registration) Regulations 2009.

Working in partnership with others
•The service worked in partnership with key organisations, including the local authority and health and social care professionals. However, feedback received from the service commissioner was not positive. They told us that they had concerns about this service as no improvements had been made since the last inspection.

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
Treatment of disease, disorder or injury	People did not receive person-centred care.

The enforcement action we took:

Vary condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not always cared for by staff who respected their dignity and respected them

The enforcement action we took:

Vary condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People's care and treatment were not always planned and managed in a way that promoted the health, safety and wellbeing of people. Medicines were not safely managed. People's observation charts, elimination charts and food and fluid charts were not always completed to ensure people's safety.

The enforcement action we took:

Vary condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided.

The enforcement action we took:

Vary condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitments checks were not robust to ensure they were of good character, had the right qualifications, skills, experience and were competent to carry out their roles effectively.

The enforcement action we took:

Vary condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to meet people's needs in a timely manner. Staff training was not up to date.

The enforcement action we took:

Vary condition