St. Matthews Limited

Hawthorne House

Inspection report

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

Summary of findings

Overall summary

About the service
Hawthorne House is a residential care home providing personal and nursing care to 92 people at the time of the inspection. The service can support up to 102 people.

This is a care home that provides nursing and residential care to people living with dementia and physical disabilities. The home also offers specialist services for people with acquired brain injuries, including rehabilitation, and Huntington's disease specialist care.

People's experience of using this service and what we found
The provider failed to meet regulations to ensure people were safe and had their needs met. Systems to ensure people were safeguarded from abuse had not been addressed by the provider. People were at risk of harm, as systems to protect people were not always followed and were ineffective at identifying and managing risks. People did not always receive their medicines safely. There were not always sufficient staff to ensure people received the support they needed in a timely way.

The policies and systems in the service did not support people to have maximum choice and control of their lives. However, staff did support people in the least restrictive way possible and in their best interests. Staff did not always receive the specialist training they needed to support people. People had a nutritious diet, and they enjoyed the food offered. However, the mealtime experience was not always good for people. There had been improvements made to the environment, and there were plans for further improvement to adapt the environment to meet people's needs. People had their needs assessed and received the health care they needed.

People and their relatives said they were supported by kind and caring staff. However, the provider did not always show compassion for people by ensuring there were sufficient staff to meet people's needs and spend time with them. Feedback from people living at the home was not always actioned so that improvements could be made.

People did not always receive the support they needed. People's records did not always guide staff to provide personalised support. People had some access to interesting things to do. The management team were recruiting extra staff to improve people's social inclusion and provide interesting things to do. People's end of life plans needed additional information to ensure they were up to date. Complaints were investigated and outcomes actioned, although relatives did not always feel listened to.

The service was not well-led. For the second consecutive inspection, the provider continued to lack effective governance systems to identify shortfalls in the quality and safety of the service. The provider's governance systems had failed to ensure people were protected from the risk of harm and agreed safety measures were put in place. Systems to provide an overview of clinical governance were not effective because staff were not given time to complete checks. Actions identified were not consistently addressed and, therefore, there was

a lack of continuous learning and improving people's safety and outcomes.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 March 2019).
The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection not enough improvement had not been made and the provider was still in breach of regulations.

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

Enforcement
We have identified breaches in relation to protecting people from abuse, safe care and treatment, sufficient staffing, consent to care, good governance and failure to notify at this inspection.

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

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

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 for the provider to understand what they will do to improve the standards of quality and safety. We will work with the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.
Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.
Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.
Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.
Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.
Details are in our well-Led findings below.

Inadequate

Hawthorne House

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 team consisted of three inspectors, two assistant inspectors and a Specialist Advisor who was a specialist in acquired brain injury services. There was also 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
Hawthorne House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our 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.

During the inspection
We spoke with nine people who used the service and eight relatives about their experience of the care provided. We spoke with 26 members of staff including the clinical director, registered manager, deputy manager, clinical leads, unit lead, nurses, senior care workers, care workers, head of maintenance and the chef. 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 spoke with one professional who regularly visited the service.

We reviewed a range of records. This included sampling 24 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider's systems and processes for safeguarding people from abuse were not always operated effectively so they could immediately investigate any allegations or evidence of abuse. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insufficient improvement had been made at this inspection and the provider continued to be in breach of regulation 13.

● People were not consistently protected from the risk of abuse. For example, one person had allegedly experienced three episodes of sexual abuse since November 2019 by two different perpetrators. The registered manager was not aware of two of these incidents of abuse and had not investigated or reported these to the correct authorities. However, following the third incident appropriate action had been taken and the person had moved to a different unit. The provider had failed to ensure people were safeguarded from abuse.
● Unexplained bruising on people living at the home was not consistently investigated to ensure people were not subject to abuse. For example, staff had identified and recorded that one person had unexplained bruising. However, the provider had not completed any investigation into the cause of this bruising. This had been previously evidenced as an area requiring improvement at our last inspection and had not been addressed.

After these concerns were identified by us the provider took immediate action to investigate and reported abuse to the correct authorities.
● Staff received regular training about protecting people from abuse. However, some staff did not always understand how to recognise signs of potential abuse or that these needed to be reported for further investigation.

Assessing risk, safety monitoring and management; using medicines safely learning lessons when things go wrong
● The provider failed to consistently identify and investigate accidents and incidents to ensure people were protected from avoidable harm. For example, one person had had seven falls in February 2020 which had not been investigated and actions taken to reduce the risk of harm.
● The provider failed to ensure risks to people were identified and actioned. For example, one person, who

had lived at the home since 2017, did not have the equipment they needed to protect them from the risk of sore skin. After the inspection team brought this concern to the provider's attention, appropriate equipment was provided. However, this had not been identified by the provider's systems.

● Medicines were not managed safely. For example, one person received out of date medicine and staff had not identified the risk. Staff did not consistently record the opening dates of people's medicines to ensure they were monitored and not at risk of receiving out of date medicine.

● The provider's systems failed to ensure people had their medicines as prescribed. For example, one person did not receive their medicine as prescribed. The registered manager investigated this, after we brought it to their attention, and found there was an error on the medicine record. However, this had not been identified in the regular checks to ensure people had their medicines as prescribed.

● Controlled medicines were not monitored safely to ensure people were not at risk. For example, we found on two separate units there were missing controlled medicines which had not been identified or investigated.

● Protocols to guide staff where people were prescribed medicines 'as required' did not always provide sufficient detail to support staff to administer medicines consistently. For example, there was a lack of individual information about how staff could identify pain in each person to guide them in administering pain relief when needed. Diabetes protocols did not always include individual information about acceptable blood sugar readings for each person. Agency nurses worked at the home on a regular basis who would not know people so well, including the normal blood sugar range for those with diabetes.

● Medicines were not always stored safely, which put people at risk. For example, we saw on one unit fluid thickener was stored in an unlocked cupboard in the kitchenette. This was accessible to people living on the unit who may not have been aware of the associated risks of ingesting this powder.

● People were at risk of not receiving the care they needed when they needed it. The call bells were situated in an office on each unit and, when the door was closed, staff could not consistently hear the call bell and respond to people's needs. We saw examples where care staff were unaware the call bells were ringing because the call bell system was able to be muted by staff working in the office. On one occasion, the inspector intervened to alert the care staff to attend to people's needs and inspector had to remind staff to unmute the system when leaving the office.

● People who had incidents related to how they behaved did not have these incidents reviewed to improve their well-being and support staff and other people living at the home. We found behavioural charts were completed by staff. However, these were not reviewed consistently to look at improving people's outcomes.

● Systems to monitor people's risks were not consistently applied to ensure people were not at risk of harm. For example, one person's dressing changes for a pressure sore had not been recorded regularly to show when the dressings were changed. This had not been identified and the person's pressure sore remained unhealed. Food and fluid charts were not monitored effectively to identify gaps in recording which put people at risk.

● Staff did not always report concerns about fixtures and furniture to the maintenance team. For example, we found, over the first two days, there were broken internal doors and drawers on one unit. We spoke with the maintenance team who were not aware action was needed to protect people from potential harm.

We found no evidence that people had been harmed. However, people were not protected from the risk of potential harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our findings immediately during and after the inspection.

● The provider confirmed staff understood how to record accidents, so they were identified correctly for management investigation.

● The management team actioned the medicine concerns and ensured protocols were updated with clear

directions for staff. Medicines were stored safely, missing controlled medicines were investigated and more robust systems put in place to monitor them.
● The call bell system was reviewed to relocate the sound system, so all staff could hear and respond quickly.
● The management team agreed to review behavioural charts and improve people's outcomes. They also assured they would look at all dressing records and food and fluid charts to put a system in place to identify when they were not completed to keep people safe.

Staffing and recruitment
● There was a lack of sufficient skilled staff to meet people's needs consistently. People and their families told us there were not always enough staff available to meet their needs. For example, quality questionnaires completed by people living at the home in October 2019 had identified that people were not happy and did not feel safe. The management team told us since the questionnaires were received there had been a further reduction in the staff to people ratio leading to a reduced number of staff available.
● Staff told us there were insufficient staff available to meet people's needs, and people were at risk as a result. Staffing levels were discussed at staff meetings, and staff told us they had raised concerns regularly.
● The inspection team identified many examples where people were waiting for support because there were insufficient staff. For example, on one unit a person waited over 30 minutes to have their call bell answered. On another unit, one person had to wait 17 minutes to be taken out of the dining room because a staff member was completing their own meal. Inspectors saw staff were task focussed and were sometimes brisk with people because they lacked the time to spend supporting them.
● The provider failed to consistently maintain their own agreed staffing levels of one member of staff to four people. The staff to service user ratio was set at the lowest possible level. For example, there were 15 people living on one unit on the 2 March 2020, one of whom required one to one support throughout the day. There were three staff, including the nurse or senior care staff on duty, to support the remaining 14 people on this unit.
● Relatives told us there were not always enough staff to support people to eat their meals in a timely way. One relative explained that, due to this, they visited at meal times to support their family member to eat.
● The provider failed to monitor staffing levels and identify or take into consideration non-personal care tasks that staff were required to complete. The dependency tool included nurses and senior care assistants who had other responsibilities such as medicine administration, accident and incident reporting and managing the deployment of staff to ensure people's needs were met. For example, there were 12 people living on one unit, nine of whom needed two staff for all their personal care needs and support with eating their meals. There were three staff allocated to the unit, two care staff and a nurse, who also provided nursing support across two other units and administered medicines. Therefore, people on this unit would have to wait their turn to receive the support they needed at certain times of the day. Senior carer staff and nurses were included in dependency levels to support people's needs. However, they had additional roles such as medicine administration and audits to ensure people received quality support.

We found no evidence that people had been harmed. However, people did not consistently receive the support they needed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They agreed to review staffing levels and ensure staffing was increased where possible despite fluctuating numbers of people living at the home.
● Staff we spoke with told us they had provided references to the provider and there were checks in place to ensure they were suitable to be employed at the service. We saw this practice was reflected in staff files.

Preventing and controlling infection

● Measures were in place to control and prevent the spread of infection. Staff completed infection control training and were knowledgeable about the requirements. We observed staff using personal protective clothing and equipment safely.

● There were cleaning schedules in place to ensure standards of hygiene and cleanliness were maintained.

Requires Improvement

Is the service effective?

Our findings

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

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider failed to ensure decisions were made within the legal framework (MCA) and people's rights were protected. People's capacity assessments were not always about a specific decision, fully completed or reviewed regularly. For example, one person who had their medicines covertly had not had this decision reviewed since 2018.
- Where people lacked the capacity to make a decision, best-interest decisions were not always recorded to evidence the involvement of people who knew the person's wishes best.
- Where there were restraint protocols in place to guide staff with how to support some people, the legal framework (MCA) had not been applied. Therefore, people may have been restrained unlawfully.

We found no evidence that people had been harmed, however, systems in place did not consistently ensure people's consent was sought lawfully within the MCA framework. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had an understanding of the MCA principles and followed least restrictive practice.
- DoLS applications had been made when required. However, conditions associated with people's DoLS authorisations were not consistently kept under review. For example, we found the DoLS authorisation for one person had a condition that had not been completed. The nurse ensured this was completed as soon as we identified the issue.

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

● People were not consistently provided with a social mealtime experience they enjoyed. We saw examples where people experienced chaotic support from staff. Some people's mealtime lacked effective staff deployment or sufficient staff to meet people's needs. For example, on one unit, staff were eating their own meals, and this delayed their responses to people during the mealtime.

● The provider's quality assurance lead had identified that improvement was needed in people's mealtime experience. However, these improvements had not been completed at the time of the inspection.

● People said they enjoyed their meals and were offered choices about what they ate and drank. Relatives said they thought the food looked good.

● People were provided choices of meals and the chef told us of their plans to meet with people to improve feedback and people's satisfaction with food. Where people needed special diets, associated risks had been assessed and staff were aware of these.

Staff support: induction, training, skills and experience

● Staff did not always have the training they needed to support people. Staff told us they needed additional training, such as how to provide positive behaviour management. We discussed this request for training with the provider. They agreed this training was needed and assured us they had training resources to provide this to all staff as soon as possible.

● People and their relatives said staff were skilled and competent.

● Staff told us they had completed training when they first started their role. They were supported by experienced staff who shared best practice knowledge. They said the management team completed regular competency checks so they were confident they were completing their role effectively.

● Ongoing training updates were arranged for staff, and staff said they were encouraged to further develop their knowledge and skills through vocational training.

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

● There had been some adaptations completed on the different units since our last inspection. However, further improvement was needed across the different units to ensure the environment was suitable for people's needs. There was a lack of adaptations to the environment for people living with dementia or mental health needs. For example, there was a lack of tactile objects people could touch and hold to stimulate their minds.

● There were plans to develop some areas, such as the garden, to improve stimulation and accessibility. However, these had not been completed at the time of inspection.

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

● Assessments were completed prior to people arriving at the service and these were used to inform people's care planning.

● Staff used nationally-recognised tools to assess risks of pressure ulcers, nutritional risk and falls risks.

● Information on best practice guidance was available for staff.

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

● People could access healthcare services when they needed to.

● The clinical nurse leads had established links with health professionals, such as the GP and mental health team, and practiced a multidisciplinary approach with regular review meetings. We spoke with a community physiotherapist who regularly visited the home. They were confident staff supported people well and appropriate guidance was sought and followed as needed. We saw appropriate referrals were made to support people with their health needs.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- The provider did not evidence they understood the importance of ensuring staff had the time to provide compassionate support when people needed it. Staff did not always have time to sit and talk to people for any meaningful length of time at certain times of the day. Staff were unable to be flexible when supporting people with their personal care on some units because of the lack of staffing support. Staff told us there were insufficient staff available and this impacted on how they supported people.
- Staff were usually kind and caring. However, at busy times, such as mealtimes, staff were sometimes task focused and abrupt with people. People told us staff were considerate and kind. One person said, "The staff are all very good, all kind. All [staff] have been alright to us."
- Staff demonstrated sensitivity and consideration about issues around equality, diversity and human rights. Staff were quick to pick up on non-verbal messages from people and react to them. For example, a member of staff knew from a person's body language they needed some support, they offered the extra support discreetly. We saw examples of staff being kind and caring throughout the inspection.
- Relatives said staff knew people well and were very kind and patient. One relative told us "I get on with the staff. I have not seen anyone be aggressive to anyone."

Respecting and promoting people's privacy, dignity and independence

- People did not consistently have their dignity respected. For example, we saw one member of staff eating their own meal whilst supporting a person to eat theirs. We spoke with the clinical lead who confirmed this was not the agreed practice.
- However, people told us staff respected their privacy and dignity. Relatives confirmed their family members' dignity was maintained. One relative said about staff, "Yes, they treat them [family member] with dignity and respect. They knock the door and if they see me will leave us alone."
- People were not always able to be as independent as possible. Some people were unable to access the garden area to maintain their independence. Improvements were needed to make the garden fully accessible, for example to wheelchair users. Staff tried to encourage people's independence. One person explained they could go outside whenever they wanted, and they enjoyed the freedom to do so.
- We saw staff were careful to close doors when assisting people in their own rooms and knocked on people's doors before entering. People's dignity was maintained when staff supported people to mobilise.
- Staff were respectful of people's needs, for example making sure they were at the same level as people when they spoke with them.

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

● People were not always happy with the support they received. In a recent quality questionnaire survey, completed in October 2017 by 25 people living at the home, seven people answered that they were not happy. The action plan of monthly meetings with people living at the home had not been implemented at the time of the inspection.

● People were supported by staff who offered them choice and control where possible. One person said, "Yes, they [staff] listen to me and act on what I say."

● Relatives were involved in the care of their family member and said they were normally included and updated by staff, although it was sometimes hard to speak to the management team. One relative told us they would like to be more involved and feel listened to by the management team.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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

● People did not consistently have their needs met. At times and across different units there were not always sufficient staff available to ensure they were responsive to people's needs. Staff did not always have time to spend with people to provide quality care that wasn't task focussed. People told us staff responded to their needs, staff knew them well and worked hard to provide quality care.

● At our last inspection we identified care planning documents did not consistently provide person-centred guidance for staff. At this inspection we found the care planning documents continued to need updating for consistency, and information collected about people's needs and risks needed to be incorporated into care planning to guide staff. For example, oral care risk assessments had been completed, but not consistently incorporated into care plans to support staff. We found one person had problems with their teeth, yet there was little guidance for staff on how to support with this.

● People said staff knew them well and regular staff had the knowledge to provide personalised care.

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

● At our last inspection we identified there was improvement needed to establish interesting things for people to do around their individual interests. Staff told us they did not have time to support people to avoid social isolation.

● At this inspection there had been improvement through the on-going recruitment of activity staff, who were tasked with providing interesting, individualised activities for people at the home. There were regular dedicated staff to complete different activities with people. However, the registered manager was continuing to recruit to posts, and some units were not supported with regular activity staff. We saw on some units the activity staff adapted their program to meet people's needs. For example, where people were unwell and in bed, they provided one to one support with activities including reminiscing or reading to people. This was not consistent across each unit at the home.

● People and their relatives had mixed views about the support they had to do interesting things. One relative said, "[Staff member] does something with [family member]. They go walking and play ball. [Staff member] tries something with everyone on here [unit]." Another relative told us, "There is a lack of activities, no entertainers." We saw there were occasions when entertainers visited the service.

● There was a lack of materials in communal rooms, such as board games or interactive artefacts to capture people's interest, which meant people were mostly reliant on staff for intellectual stimulation. The registered manager was exploring the use of new technology, such as interactive tables, to improve stimulation for people.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The management team were aware of the Accessible Information Standard and told us of ways in which they were meeting the standard. For example, they provided information to people in different formats when needed.

● Staff knew how to communicate with people to understand their wishes, including when people were less able to communicate verbally.

Improving care quality in response to complaints or concerns

● People could make a complaint to the provider if they needed to. One person said, "[I have] not made a complaint. They look after us." The quality questionnaires completed in October 2019 showed that 10 people out of 25 who responded were not sure how to complain.

● Relatives knew how to make a complaint, although some relatives said they did not always receive a response and the registered manager was sometimes hard to communicate with. One relative explained they had contacted the provider when they were not happy with a particular issue, and the registered manager was addressing their concerns.

● We saw where complaints were made, these were investigated, and the complaints policy followed by the registered manager. The registered manager reviewed complaints with the provider to Identify areas for improvement in the service.

End of life care and support

● Staff were skilled in supporting people with end of life care when this was needed. They were knowledgeable about how to respect people's needs and wishes.

● The management team were aware the views of people and their families regarding end of life care was not always fully captured in staff guidance and were reviewing this.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider's systems and processes for ensuring people receive quality care were not effective. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insufficient improvement had been made at this inspection and the provider continued in breach of regulation17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems were not in place to support people to have better outcomes.
- The provider had failed to ensure concerns evidenced at the last inspection were actioned and improved. The systems in place to identify, investigate and action safeguarding concerns were not effective. For example, one person living at the home had been exposed to three occasions of sexual abuse, the first two of which had not been investigated or reported to ensure people were protected from abuse.
- The provider's systems continued to fail to ensure falls were investigated and actioned to ensure lessons were learnt and people's risks were mitigated. For example, we identified one person had had seven falls in February 2020. However, only two of these falls had been recorded on the registered manager's systems to review and mitigate their risk of harm.
- The provider's systems to ensure people had their medicines safely did not protect people from the risk of harm. Regular audits were completed yet failed to identify the medicine concerns we identified, such as poor controlled medicine management and unsafe medicine storage. Audits stated that checks were made yet these had not identified the concerns we found.
- The provider failed to ensure systems in place protected people's rights. Checks completed failed to identify shortfalls in compliance with the Mental Capacity Act 2005 (MCA) framework. Therefore, people's rights were at risk of not being upheld. For example, when people had a restraint plan, the MCA framework was not complied with to ensure decisions were made in their best interest.
- The provider failed to take action to improve shortfalls identified. At our last inspection the systems to monitor and support people who sometimes had behaviours that challenged were not consistently

reviewed to ensure lessons were learnt and outcomes improved. This was also on the action plan from the recent local Clinical Commissioning Group's visit. At this inspection it remained a shortfall, there was no system to consistently review behavioural charts to identify trends and create guidance to support staff.
● The provider failed to identify shortfalls in staffing levels to ensure people had the support they needed. The systems to gather feedback from people and their relatives failed to influence decisions about staffing levels made by the management team. Tools used to support the assessment of the level of staff needed to meet people's needs failed to take into account other roles and responsibilities of staff included in the dependency tool.
● The provider had not actioned shortfalls in training and best practice support. For example, systems were not in place for staff to request support for supporting people with epilepsy. Therefore, epilepsy care plans lacked the specialist knowledge to ensure people's care needs were met safely.
● The management team did not promote a culture of listening to people, relatives and staff when suggestions were made for improvements. This included concerns raised regarding staffing levels.

The provider responded immediately during and after the inspection. They reviewed staffing levels and agreed to increase numbers to provide more support and to improve staff capacity to follow the provider's systems to improve the quality of care.
● Safeguarding concerns identified were investigated and actioned. Systems to record, action and review accidents and incidents were reviewed and updated.
● The management team reviewed the medicine shortfalls and updated the systems in place to manage medicines.
● The management team agreed to review behavioural charts to improve people's outcomes. They also assured us they would look at all dressing records and food and fluid charts to put a system in place to identify when they were not completed to keep people safe.
● The clinical director agreed to arrange best practice support for epilepsy from their other services.
● The registered manager was working with the provider to complete improvement plans to raise standards. They had recently recruited three clinical leads to support the registered manager to achieve these improvements.

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

At our last inspection the provider failed to notify us of serious injuries and safeguarding's which was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found a further two incidents where a person living at the home had been exposed to abuse and this had not been reported or investigated. This was a continued failure to notify breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● Where accidents and incidents were identified and investigated the registered manager understood the need to be open and honest which included contacting families when mistakes happened. We saw examples where the registered manager had completed this.

Working in partnership with others
● The registered manager had improved community links and was working with other professional bodies to achieve a multi-disciplinary approach to improve outcomes for people.