St Martin's Residential Homes Ltd

St Martins

Inspection report

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Coventry
West Midlands
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Tel: 02476621298

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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:
St Martins provides accommodation and personal care for up to 16 adults and older people, some of whom may be living with dementia, mental ill health, physical or sensory disabilities. At the time of our visit 14 people lived at the home. This included two people in short term discharge to assessment beds which are used to support timely discharges from hospital. One person was in hospital. Accommodation is provided in a single storey converted house.

People's experience of using this service and what we found
Ineffective governance and lack of provider and management oversight meant previously demonstrated standards and regulatory compliance had not been maintained. The provider's systems and processes designed to identify shortfalls to ensure the service was delivered safely, and to drive improvement were ineffective. This demonstrated lessons had not been learnt since our last inspection. The introduction of new systems and processes were not well-managed. This meant staff did not have all the information they needed to provide safe care. Systems used to share information with staff were not effective.

Risk associated with people's care and the environment were not always identified, assessed and well-managed. The prevention and control of infection was not managed safely and in line with government guidance. Staff had been recruited safely and understood their responsibilities to keep people safe. People felt safe. However, people's quality of life was negatively affected by staffs' limited availability. The provider was exploring a range of ways to try to address staff recruitment challenges. People's medicines were not managed and administered safely in line the provider's procedure and best practice guidance.

Staff training was not up to date and some staff had not completed an induction to ensure they had the information, knowledge and skills to fulfil their role. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People had access to health and social care professionals.

People and relatives spoke highly of the staff who cared for them. Staff were caring in nature but did not have the time needed to provide person centred care. People's rights were not always promoted and upheld. Confidential information was securely stored.

People's needs were assessed prior to moving into St Martins. However, assessments needed to be further developed to ensure protected characteristics under the Equality Act 2010 were fully considered. The manager was planning action to address this. Care records did not always provide staff with the information they needed to deliver personalised, safe care or contained out of date and conflicting information. People and a relative felt able to raise any complaints and concerns. People had limited opportunities to take part in meaningful activities.

Feedback from people, relatives and staff was used to drive service improvement. Despite our findings, people and a relative told us they were satisfied with the service provided and staff felt supported by the manager.

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

Rating at last inspection
The last rating for this service was good (published 7 August 2019).

Why we inspected
The inspection was prompted in part due to concerns received about people's safety, poor environmental standards and staffing levels. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring and responsive and well-led sections of this full report.

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

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

We identified breaches in relation to governance of the service, management or individual and environmental risk, including fire safety, staffing and restrictions on people's liberties.

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

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will 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.

Special measures
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**

St Martins

Detailed findings

Background to this inspection

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

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

Inspection team
Day one of the inspection was conducted by two inspectors. One inspector returned for a second day to complete the inspection.

Service and service type
St Martins 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. At the time of our inspection management support was being provided by an acting manager. The acting manager is referred to as the manager in this report.

Notice of inspection
The inspection was unannounced.

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

provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people and a relative about their experience of the care provided. We spoke with 12 members of staff including the nominated individual, the operations manager, the manager, senior carers, care staff, a domestic assistant and the cook. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with an occupational therapist who visited the home.

We reviewed a range of records. This included six people's care records and medication records. We looked at three staff files in relation to recruitment and support and a range of records relating to the management of the service, including audits and checks, policies and procedures, training data, and quality assurance records.

After the inspection
We continued to seek clarification from the nominated individual, operations manager and manager to validate evidence found. We looked at training data, risk assessments, mental capacity assessments 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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Lessons learnt

- Risks to people's safety, health and wellbeing were not always assessed or well-managed.
- One person was diabetic. Staff confirmed a diabetes risk assessment had not been completed. Despite the manager's assurance this would be addressed, on day two of our inspection a risk assessment had not been completed. This meant staff did not have the information they needed to provide safe care.
- The same person was known to be at risk of choking. The manager told us the person had chosen not to add thickening agents their drinks as recommended by a speech and language therapist to reduce this risk. However, a choking risk assessment had not been completed to inform staff of the actions they needed to take if the person choked.
- Another person required the use of bedrails to reduce the risk of them falling out of bed and being injured. Risks associated with the use of the bedrails had not been assessed. Furthermore, the bedrails had been used without the required safety bumpers. The use of bedrail bumpers is important to prevent entrapment and impact injuries. Action was taken to address this.
- The same person's risk assessments had not been reviewed or updated on discharge from hospital to reflect changes in their needs. This meant staff did not have the accurate information they needed to provide safe care.
- Environmental risks, including fire safety risks were not always identified and well managed.
- Previously, important information needed by the emergency services to keep people safe was not up to date. At this inspection those concerns remained. This was despite the manager assuring us the information would be updated to improve safety.
- On day one of our inspection visits we saw an overflowing metal ashtray in the designated smoking area contained flammable items including, empty cigarette packets and paper. This created a fire risk. The manager confirmed the metal ashtray was not regularly checked and emptied. They assured us this risk would be immediately mitigated. During day two of our inspection this fire risk remained.
- An external set of doors in the communal lounge marked as a fire exit did not open and close correctly. One person told us, "It's been like that since the summer." On day two of our inspection, the doors were repaired.
- During day one of our inspection visits two bedroom doors were wedged open. This was unsafe because the doors would not close in the event of a fire to keep people safe. We saw staff walked past those bedroom doors did not recognise this risk. Despite alerting the manager and staff to this fire safety risk, when we returned on day two the same doors were wedged open by staff. The operations manager took action to address this.
- Fire safety was not managed in line with the providers policy and procedure. For example, a plan of the building and essential equipment detailed in the providers 'Fire Evacuation Plan' was not available

including torches and high visibility tabards. This placed people at risk in the event of an emergency.
● Staff responsible for the safety of people at night-time had not been involved in fire drills in line with requirements detailed in the providers policy and procedure. Other staff were not fully familiar with the homes fire procedure and their responsibility in relation to this. The operations manager assured us this would be addressed.

We found no evidence that people had been harmed however systems and processes were not sufficient to demonstrate risk associated with people's care and safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we were informed of the reactive action taken to mitigate the risks we identified.
● Despite our findings people felt safe and were confident staff understood how to provide safe care. One person said, "I am ok here. I would say I am safe. It's all good. The staff know how to help me." A relative told us, "I think [person] is safe and well. I haven't worried about safety."
● Accidents and incidents had been recorded. However, follow up information on the accident and incident forms had not been completed. This meant potential opportunities to learn lessons and prevent a re-occurrence had been missed.

Using medicines safely
● People's medicines were not always ordered, stored, administered and managed safely. This placed people at risk.
● Some staff responsible for administering people's medicines had not completed medicines training. One staff member said, "I haven't done any meds training. I did watch a senior do meds and had my competency assessed." Records confirmed this.
● One person's prescribed medicine required stricter controls in relation to how it was stored, recorded and administered. The physical stock of this medicine did not tally with the amount recorded as received and administered. This was despite senior care staff checking and recording the stock as correct on six occasions between 5 and 10 October 2021. This demonstrated the checks were ineffective.
● Another person's medication administration record (MAR) showed a prescribed medicine was out of stock. The manager told us they were waiting for the medicine to be delivered. However, we saw a newly dispensed box of this medicine in the medication room. The medication had not been booked in on receipt. This meant staff were not aware the medication was available, and the person had not received their medicine as prescribed on three occasions.
● We saw a blister pack containing another medication for the same person in the medication trolley. The MAR records showed the medication had not been administered but did not give a reason for this. When we asked staff why the medication had not been given one staff member replied, "The others [senior carers] did not give it so I didn't. I think it is because [name] is on antibiotics." There was no information in the person's care records to confirm this. The manager assured us the person's records would be updated.

We found no evidence that people had been harmed however systems and processes were not sufficient to demonstrate people's medicines were managed and administered safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Low staffing levels impacted negatively on people's safety and experiences of living at St Martins.
● People told us there were not always enough staff on duty. Comments included, "This time is the worst

time of day for staffing. Only two of them, most days", and "Just the two girls on, at teatime. They are so busy; I don't ask for anything as I can see they are busy."
● Staff agreed staffing levels were too low, particularly at times when care staff had responsibility for non-care tasks, including meal preparation, laundry and cleaning. One told us, "In an afternoon we often work with two, It's just not enough." Another said, "Well, we just kind of manage…but if we are in someone's bedroom, other residents would be unsupervised…we do our best." Staff told us the manager was actively trying to recruit new staff to make improvements in this area.
● Our observations confirmed staffing levels were too low. We saw a staff member had to stop administering people's medicines to assist a person walking across the lounge using their walking frame. This was because no other staff were available to provide the support the person needed. The staff member told us, "[Person] needs to be watched, she could fall." At other times people who were highly dependent and unable to summon assistance were unsupervised in the lounge.
● The manager used the provider's 'dependency tool' to establish staffing requirements. However, staffing levels at the time of our inspection visits were below those assessed as required. This placed people at risk of potential harm.

We found no evidence that people had been harmed however, the provider had failed to ensure there were sufficient numbers of staff available to meet people's needs This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The nominated individual described staff recruitment and retention as the services biggest challenge. To try to address this they had commissioned the services of a consultant specialising in recruitment. The Director added, "We are trying everything we can think of. They [consultant] may be able to tap into markets we don't know about."
● Previously, records did not demonstrate all staff had been recruited safely in line with the providers procedure for completion of pre-employment checks. At this inspection improvements had been made. Records confirmed staff had been recruited safely.

Preventing and controlling infection
● We were not assured the provider was preventing visitors from catching and spreading infections. The signing in book showed seven visitors had entered the home between 01 and 07 October 2021. COVID-19 screening in line with the providers procedure had not been completed. On day one of our inspection visits inspectors were not screened prior to being permitted to enter the home.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules were not completed to demonstrate frequently touched points were regularly cleaned for example, door handles and handrails.
● We were not assured the provider's infection prevention and control policy was up to date in line with current guidance and implemented effectively to prevent and control infection. The homes infection and prevention control lead had limited knowledge of their role and responsibilities and infection prevention and control audits had not identified the shortfalls we found.
● We were not assured the provider was using PPE effectively and safely. Some staff were observed to be working without wearing a face mask.
● We were not assured the provider was meeting shielding and social distancing rules. People isolating in line with current guidance to prevent the potential spread of infection used communal toilets and staff were observed taking their breaks together sat at a table in the middle of the home's kitchen.

We found no evidence that people had been harmed however government guidance was not followed to

ensure risk associated with the prevention and control of infection was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We were somewhat assured the provider was making sure infection outbreaks could be effectively prevented or managed.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were somewhat assured the provider was accessing testing for people using the service and staff.

Systems and processes to safeguard people from the risk of abuse
● Most staff had completed safeguarding training and demonstrated some understanding of the types of abuse a person may experience and their responsibilities to report any concerns to keep people safe.
● The manager had referred safeguarding concerns to the local authority and CQC as required to ensure the concerns were investigated. Records confirmed this.

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 management team had a limited understanding of the requirements of the MCA. For example, a DoLS application for one person had been submitted to the local authority. However, there was no information available to show a mental capacity assessment had been completed. Another person's consent to care document had been signed by their relative and the manager despite the person having capacity to make their own decisions.
- Records confirmed two people's urgent DoLS authorisations had expired. New applications had not been submitted and those people continued to have restrictions placed on their liberty to keep them safe. Progress of a standard DoLS application for a third person, submitted in March 2021, had not been checked. This demonstrated people's liberties were being restricted without the required legally authority to do so being in place. The quality manager assured us they would address this.
- Care records for people assessed as not having capacity did not clearly document who and how best interest decisions should be made.
- MCA training for staff was not up to date. Despite this we saw staff worked within the principles of the Act by seeking people's consent prior to providing support.

We found evidence people's liberty had been unlawfully restricted. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the manager confirmed DoLS authorisation requests had been submitted.

Staff support: induction, training, skills and experience

● Staff training was not up to date, including training the provider considered essential to ensure staff could fulfil their role safely. The provider offered financial incentives to staff to complete their training in their own time. They told us this was to try increase staff availability to cover the staffing rota. Records confirmed this.

● Some staff were not familiar with the providers fire safety procedure, including staff responsible for people's safety at night-time.

● The providers staff induction reflected nationally recognised induction standards. However, not all staff working at the home and who were responsible for leading the night-time shift had completed their induction or the training the provider considered essential including fire safety training. This exposed people to unnecessary risk.

We found no evidence that people had been harmed however, the provider had failed to ensure they had prepared staff for their roles. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the quality manager confirmed action had been taken or was planned to address these concerns.

● Staff received support through individual and team meetings. One staff member told us, "Just recently. Really since [manager] came we have started to have supervisions and meetings again. I think this will help."

● Despite our findings people and relatives had confidence in the skills and knowledge of staff.

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

● Further consideration was needed to ensure the environment met the needs of all people. For example, people accessed the designated smoking area via a door in the communal lounge. The weather was cold during our visits and we saw highly dependent people in the lounge used blankets to keep warm as the door was frequently opened because the smoking area was in constant use. There was a lack of signage displayed to assist people living with dementia to navigate around their home.

● The provider had devised a building improvement plan and investment was being made to update the homes environment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law: Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People's needs were assessed before they moved into the home. However, the provider's assessment did not include encouraging people to share important information about their preferences and lifestyle choices. The quality manager told us, "I amended the assessment to include information about religion, culture, gender preferences. It looks like the old forms been used. I don't know why. I will email all managers."

● People had access to a range of health and social professionals. During our visit some people received visits from mental health professionals and an occupational therapist (OT). The OT described staff at St Martins as 'friendly and helpful'. They added, "They must be doing what we asked as [person] is now walking with their frame."

● Whilst the manager and staff consulted with healthcare professionals the advice they provided was not always clearly recorded and followed.

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

● People provided positive feedback about the food. One person explained they had enjoyed their pudding because they had a sweet tooth. Another person said, "I get lots of choice. If it looks good and smells good its right for me."
● Care records contained some information about people's nutritional needs and preferences and any risks associated with eating and drinking. However, some records were not accurate and up to date. Despite recording omissions staff demonstrated they understood people's likes, dislikes and 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.

Respecting and promoting people's privacy, dignity and independence

- People's right to privacy was not always understood and respected. On day one of our visits the manager invited the inspection team to base themselves in a bedroom that belonged to a person who was in hospital and some staff entered people's bedrooms without seeking permission.
- Low staffing levels meant people's dignity was not always promoted and upheld. We saw one staff member assisted a person to eat their lunch whilst standing up. The staff member told us, "I do it like this so I can move between residents who need help." No other staff were available to assist people with their meals as they were busy undertaking other tasks.
- Most staff understood the importance of promoting people's independence. For example, one staff member supported a person to walk independently by giving verbal encouragement and reassurance. The staff member told the person, "You're amazing. Well done." The person replied, "Thank you so much."

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People and a relative spoke highly of staff. Comments included, "The girls seem very kind. [Person] likes them", "I am happy enough here, staff are pleasant…I think staff have my best interest at heart. They are kind girls", and "I only have to ask and they [staff] will help me."
- Staff supported people in a kind way and demonstrated a caring attitude. However, they were not always able provide timely personalised care because they were busy which meant they were task focused. One staff member told us, "We can be very rushed…we don't have time to sit and chat with the residents…We just have to crack on."
- Staff enjoyed their work. One staff member said, "This is the best job I have ever had. I love coming to work." Other staff told us they found their work rewarding with one commenting, "When I have done my very best for the residents, I know I've had a good day."
- Care records contained some information about people's preferences and beliefs.
- Most staff had completed equality and diversity training. When discussing equality and diversity the manager told us, "This is an area for further development."
- Staff understood the importance of respecting people's choices. One staff member tried to encourage a person to put their coat on before going outside because it was raining. The person said, "I don't need my coat." Whilst the staff member respected the person's choice, they suggested the person could sit in an area of the garden that was sheltered. The person responded positively to this suggestion.
- People's confidential information was securely stored in line with legal requirements.

Requires Improvement

Is the service responsive?

Our findings

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

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

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

- People did not consistently receive personalised care that met their needs. Low staffing levels detailed within this report meant staff were not always available or did not have the time they needed to provide individualised and responsive care. For example, one person waited over twenty-five minutes before their request for assistance to leave the dining table was responded to. The person said, "It's always the same at lunchtime. The problem is the girls are so busy."
- Previously, care plans were detailed, personalised and up to date. This standard had not been maintained. For example, a care plan had not been written for a person who had type 2 diabetes. Another person's care plan did not provide staff with the guidance needed to support the person to prevent their legs from becoming ulcerated. A third person's care plan informed staff the person was not at risk of their skin becoming sore. This conflicted with information recorded in the staff handover book which stated the person had very sore skin.
- Processes used to inform staff of changes to people's needs were not effective. We saw one person had slept on a mattress on the floor in their bedroom because risk mitigation measures had not been clearly communicated to staff. When we alerted the quality manager, they took immediate action.
- The provider was in the process of implementing an electronic care records system. At the time of our inspection staff obtained information from both paper and electronic care records. Staff described using both systems as 'confusing'. One staff member told us, "You don't know where to look, so you can miss things." We saw information about people's needs differed depending on the system viewed and discussion with staff highlighted they had a different understanding of the needs of people recently admitted to the home. This placed people at risk.
- Despite our findings people told us staff understood how they preferred their care to be provided.

Improving care quality in response to complaints or concerns; Meeting people's communication needs

- People and their relatives knew how to make a complaint and felt able to do so. One person told us, "The owners come sometimes and ask if I am okay. I would tell them is something was wrong."
- Records showed complaints had been managed in line with the provider's procedure.
- The provider's complaints procedure was displayed in the home's reception and included information about how to make a complaint and what people could expect if they raised a concern.

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.

● Staff understood how to communicate effectively with people.
● People had access to some information in different formats including, pictorial and large print.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were supported to maintain important relationships.
● People had limited opportunities to engage in meaningful activities. A staff member told us, "The manager is trying to recruit an activity person. We [care staff] try to do it [activities] when we can but we don't have much time."

End of life care and support
● Some people living at the home were in the end stage of their lives. End of life care plans contained limited information about people's wishes and had not been reviewed as people's needs changed.
● Some staff had completed end of life training. One staff member told us, "The district nurses come in but if we are worried, we always call the doctor. We like to make sure they [people] are comfortable."

Inadequate

Is the service well-led?

Our findings

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

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

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

- The provider had failed to maintain sufficient or accurate oversight of the service. Some previously evidenced standards and areas of regulatory compliance had not been maintained. We identified four breaches of the regulations. This exposed people to unnecessary risk of harm or injury.
- Lessons had not been learnt by the provider. Improvements to the providers quality monitoring systems highlighted at our last inspection had not been made. For example, previously highlighted fire safety risks had not been addressed and medicines audits had not identified the shortfalls we found.
- The provider had failed to identify, assess and mitigate risks associated with people's care and the environment. This placed people at the risk of avoidable harm.
- The provider had failed to ensure COVID-19 national guidance was followed to keep people and staff as safe as possible during the Coronavirus pandemic.
- The provider had failed to maintain the staffing levels needed to meet people's assessed needs.
- The provider had failed to ensure staff completed an induction and the training they needed to fulfil their role. This was unsafe practice.
- The provider had failed to ensure restrictions on people's liberties were managed in line with the Mental Capacity Act 2005.
- The provider had failed to identify staff did not have the information they needed to provide safe care because the introduction of new systems, including electronic care records, was not being well-managed.
- Information the provider had submitted in their PIR was not an accurate reflection of how the service operated. For example, the PIR (information providers are required to send us with key information about their service does well, and plans for improvement) told us the provider's staffing tool ensured, 'we have suitable and adequate staff on shift throughout the day and night'. This conflicted with our inspection findings.

We found no evidence that people had been harmed. However, governance and service oversight were ineffective. Systems and processes were not established and operated correctly. There was a failure to make and sustain improvements to benefit people. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings people and relatives were satisfied with the service provided and how the service was managed. Comments included, "The new manager seems very nice and approachable" and, "I chose the home because it's small and friendly. Its personable. I am happy to talk to [manager] about things."

● The home had a registered manager as required by the regulations. However, at the time of our inspection the registered manager was not at work. Management support was provided by the deputy manager from one of the providers other locations who had been promoted to the manager role. They told us they had been in post for seven weeks. They added, "There are lots of things that are not in place. We have a lot of work to do."
● The provider had devised a service improvement plan. The manager told us the provider had agreed additional management resource to enable the improvements to be implemented.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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.
● Feedback from people and relatives was encouraged through meetings and questionnaires which was used to drive improvement. For example, in response to people's feedback new garden furniture had been purchased.
● The provider and manager understood their responsibility to be open and honest when things had gone wrong.

Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff felt supported and spoke positively about the manager. Comments included, "We have had lots of different managers. I hope [manager] stays as things are getting better now," and, "You can go to [manager] and ask about things which feels good. I think [manager] listens."
● The manager and staff worked in partnership with health and social care professionals to promote people's physical health and well-being.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured restrictions on people's liberties were authorised in line with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of staff were available to meet people's need. The provider had not ensured staff completed an induction and training to ensure they could fulfil their role competently and safely.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured care and treatment was provided in a safe way for service users. The provider had not ensured risk associated with people's care and the environment was identified and assessed. The provider had not taken all reasonably practical steps to mitigate risk. The provider had not ensured the safety of the premises. The provider had not ensured the proper and safe management of people's medicines. The provider had not ensured the prevention and control of infection in line with current government guidance during the Covid 19 pandemic.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured they had effective systems and processes in place to identify assess and mitigate risks relating to the health and safety and welfare of service users.

The provider had not ensured they had effective systems and processes in place to identify assess and mitigate risks relating to the environment, including fire safety risks.

The provider had not ensured records relating to the care and treatment of each person using the service were accurate and up to date.

The enforcement action we took:

warning notice