Aura Care Living LTD

Stratton Court

Inspection report

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Stratton
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Stratton Court is a residential care home providing personal and nursing care. At the time of the inspection 23 people received care. The service can support up to 60 older people. People are accommodated in one adapted building. Two of the three care floors were open, a third floor, specialising in dementia care, was due to open in early 2020.

People's experience of using this service and what we found
People and their representatives had mixed experiences of the services and care provided. One person who used the service said, "They look after us well here" and a relative said "I'm blessed [name] is here." Three other people's representatives told us the service fell short in several areas; these being delivery of appropriate care, consistent and effective communication and what they perceived to be an overall lack of effective management.

At the last inspection in November 2018 we found the provider had failed to effectively monitor the service to ensure it met all necessary regulations. During this inspection we found the provider was still not meeting all the required regulations. The provider had not always effectively monitored and assessed risks to people and the quality of services provided to people. We found that when they had become aware of concerns, they delayed acting on these to mitigate potential risks to people.

During this inspection we evidenced that some improvements had been made to the quality of services people received, such as improved social activity opportunities and support at mealtimes. Further work was required however, to ensure, people received safe care and treatment, that requirements in line with the Mental Capacity Act 2005 were followed and accurate records were kept of people's risks and care needs. These were areas for improvement in the last inspection which the provider had not subsequently monitored to ensure improvements in these areas were made and sustained.

Following this inspection arrangements were made by representatives of the provider to closely monitor the quality and risks in the service. An external auditor had completed a quality monitoring visit (on behalf of the provider) and planned to revisit on a regular basis. Members of the provider's senior management team were due to remain present in the home until improvements were achieved.

The service was reliant on agency staff to ensure it could operate safely. Some agency staff worked at the home on a regular basis so had become familiar with people's needs and preferences which helped. Some successful recruitment of permanent staff had taken place however, improvement was needed to establish a consistent, well-co-ordinated and informed care team.

Gaps in effective monitoring systems and clinical leadership had resulted in people's care delivery not being sufficiently monitored and a breakdown in effective communication with those who mattered about people's care and treatment. People's representatives and relatives told us they had to seek out information

about their relatives' care and often they were not informed about relevant changes or decisions made about this. The provider had not ensured that relative meetings and care review meetings had taken place.

People and their representatives and relatives told us staff were kind and caring. People's dignity and privacy was maintained during care delivery. People were treated equally and not discriminated against.

There were arrangements in place to administer people's medicines safely. Plans already in place, to provide additional staff with medicines administration training, were aimed at ensuring people received their medicines in a timely manner.

People had access to healthcare professionals although managers recognised that these arrangements needed some improvement to ensure people received more regular and planned reviews of their health needs.

Improved links with the local community and groups within it were being made so that people could benefit from these.

There were arrangements in place for complaints and concerns to be listened to a responded to, although this had not always led to learning and sustained improvements in the quality of the services provided. Work on resolving these areas of dissatisfaction were continuing at the time of this inspection.

Arrangements had been made to improve communication with both people, their representatives and staff generally and to promote a more inclusive culture. An open-door policy had been adopted by the current home manager and planned meetings with both relatives and staff took place just after the inspection visit. Future meetings were to be held with all groups on a regular basis and the views of people's representatives were soon to be sought by using questionnaires.

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 18 January 2019) and we identified three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found some improvements had been made however, planned improvements had not been successfully implemented or sustained to meet all of the relevant regulations.

This service has been rated requires improvement for the second time.

Why we inspected
This was a planned inspection based on the previous rating which was brought forward due to concerns received about the management of people's care, staffing numbers, staff skills and the management of the service. A decision was made for us to inspect and examine those risks. This inspection was also carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well-led sections of this full report. We have identified breaches in relation to the need for consent, safe care and treatment, and governance at this inspection.

You can see what action we have asked the provider to take at the end of this full report. We issued a warning notice telling the provider they needed to make the required improvements to meet the requirements in relation to Good governance by 31 March 2020.

Since the inspection the provider has kept us informed about the action they are taking to mitigate further risks to people and we have included this in the summary above.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not well-led.

Details are in our well-Led findings below.

Stratton Court

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
Two inspectors completed this inspection.

Service and service type
Stratton Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission (CQC). A member of the provider's management team was managing the service and preparing to register with CQC. This means that when they are registered, they, and the provider, are legally responsible for how the service is run and for the quality and safety of the care provided.

This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed all other information received and held about this service since the last inspection. We sought the views of commissioners of health and social care. We used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service, four relatives and the friends of one person. We reviewed seven people's care files which included care plans, risks assessments and other related care information. We reviewed records relating to the Mental Capacity Act 2005 and records relating to people's medicines. We spoke with four care staff, two registered nurses one housekeeper, the unit lead, the activities co-ordinator, the client relations manager, home manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This related to: the management of people's health risks, audits completed, staffing numbers, staff training and progress on staff recruitment. We sought further clarification on Deprivation of Liberty Safeguards and the provider's quality monitoring process. We continued to speak with healthcare professionals who visited the home.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At the last inspection the provider had failed to robustly assess and record risks relating to people's health, safety and welfare. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Some action had been taken since the last inspection to assess and record risks to people. The information however, often lacked detail about what the risks were and what action staff needed to take to reduce these. Some risk assessments were incomplete, had not been consistently reviewed and not changed when people's risks had altered. This was seen for risks relating to safe moving and handling, choking, nutrition and development of pressure ulcers. In one person's care record their assessments for safe moving and handling and prevention of pressure ulcers were completed 10 days after their admission and were left incomplete in places.
● Another person had been identified as being at high risk of falling. Although, we observed staff providing the support the person needed to stay safe during the day, for other times (at night or when staff were not nearby), there was no recorded risk management guidance or care plan for how staff were to mitigate the risk of potential falls, or, how to manage the factors which made this more challenging. This was important as records showed this person frequently walked unaided at night and when found doing this could become distressed and challenging to support; increasing the risk of falls.
● People who had known risks associated with their health conditions did not always have their needs fully identified, assessed and acted on to keep them safe. One person was able to independently monitor and manage many aspects of their care. However, when unable to do so they were reliant on the staff assessing their needs and acting, where required, to reduce further risk to their health. This had not always happened, and it had required the intervention of external healthcare professionals to support staff to understand the importance of doing this. For another person who had been admitted with skin concerns, a risk assessment for developing pressure ulcers had not been completed until nine days after their admission. We found their skin had deteriorated during this time.

Insufficient improvement had taken place to ensure risks associated with people's care were fully assessed, monitored and managed, this remained a repeated breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found that risks which may hamper successful evacuation of people, in the event of a fire, had been assessed and the action required by staff had been clearly recorded for staff guidance.
● There were additional examples, of actions having been taken to address and reduce environmental risks to people. This had included adding a secure keypad device to the lift so that people who may be at risk of using this unescorted had been mitigated.

Staffing and recruitment

At the last inspection the provider had failed to ensure staff were safely recruited. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Managers now ensured that appropriate recruitment checks were completed on staff before they started work with people. This included, obtaining references, checking employment histories and reasons for employment gaps, obtaining clearance from the Disclosure and Barring Service (DBS) and police checks.
● To ensure safe recruitment practice continued the home manager now checked that a full recruitment process had been completed before staff started work with people.
● Managers stated retention of staff had been a challenge, however successful recruitment of new staff continued to take place. Recruitment of new staff was to be an on-going process to reduce the number of agency staff used and to naturally increase staffing numbers as the number of people using the service increased. Plans were in place to recruit staff with knowledge and skills of dementia care in readiness for the opening of the dementia care floor after Christmas.
● During the inspection changes were made to the deployment of staff to ensure they were able to better meet people's needs across the two care floors. Time was needed for the impact of this revised staff deployment to be monitored and assessed to determine if it was effective in meeting people's needs.

Systems and processes to safeguard people from the risk of abuse
● Staff had received training (either through the provider or their agency employer) on how to recognise abuse and how to report safeguarding concerns.
● Senior managers ensured the provider's policy and procedures, along with local professionals' multi-disciplinary agreements on safeguarding people, were followed.
● Staff also knew how to report concerns related to poor practice or discrimination, both within their own organisation and to appropriate external agencies.

Using medicines safely
● Arrangements were in place for ordering people's prescribed medicines. Where problems had occurred, between GP surgeries and the pharmacy, in getting medicines or wound care equipment delivered in a timely way, staff in the home had followed these problems up.
● Medicines were stored and administered safely by staff who were competent to do this. On-going staff competency checks in the administration of medicines were not in place but were due to be introduced.
● Visiting healthcare professionals were involved in reviewing and administering some people's medicines, such as insulin.
● People who wished to self-administer medicines were assessed to ensure they were safe to do this.

Preventing and controlling infection

● The environment was cleaned daily.
● Staff had received training (either through the provider or their agency employer) on how to prevent the spread of infection. Staff wore disposable gloves and aprons when delivering people's personal care, washed their hands in-between attending to people and hand sanitisers were available for use both by staff and visitors in care areas.
● Arrangements were being made with the main attending GP surgery for people to receive the flu vaccine.

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 Requires Improvement. At this inspection this key question has remained the same. 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. We found the principles of the MCA were not always followed and requirements under the MCA not completed.

● Some people living at Stratton Court were not able to consent to their care and treatment. Decisions had been made about their care on their behalf. However, records did not show how people's decision-making capacity had been assessed or how decisions had been made in their best interest. One person's record stated the person did not have the capacity to make decisions but did not record which particular decision this lack of capacity referred to. They were to be supported by relevant professionals and staff involved in the person's care, including the family to make complex care decisions. Following a visit by healthcare professionals' staff had been asked to make an application for DoLS, also a significant decision had been made regarding one aspect of this person's care. There was no record of how this person's capacity had been assessed or how the decision had been made that restrictions needed to be placed on them to keep them safe. We found that a DoLS application had not been submitted to the local authority as had been requested.
● Another person's record stated the person's legal representatives were to be involved in particular decisions. However, there was no record of the best interest decision taken that this person was required to live and remain in the home under supervision, even though a DoLS application had been made and the person had not yet been assessed in relation to this. Additionally, there was no record of a mental capacity assessment having been completed by the service in relation to actions already taken. People could not be assured that their rights would be protected.
● Records available for recording consent from people or their representatives, for sharing of information and taking of photographs had not always been completed.

● Three DoLS applications in total had been submitted to the local authority, none of these people had yet been assessed by the local authority and the same lack of mental capacity assessment and record of best interests applied.
● One person's legal representative told us they had been concerned that a decision about one aspect of their relative's treatment had been made, and acted on, without consulting them.

People's mental capacity had not been assessed and best interest decisions were not recorded in accordance with the Mental Capacity Act 2005. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw before staff provided people's care and treatment they sought people's verbal or implied consent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Managers told us people's needs were assessed prior to them moving into the home. Initial information, seen recorded in people's care records, was brief, giving staff little information about people's needs and choices. Assessments and care planning was not always in line with best practice guidance as seen in the case of one person's pressure ulcer prevention assessment and care.

Staff support: induction, training, skills and experience
● We reviewed the service's staff training record which showed staff had completed induction training when they were first employed, as well as training in core subjects, which the provider considered necessary for their role. Staff were able to tell us what they would do in the event of a fire and how to report safeguarding concerns, indicating they had received induction training and training in more depth after this. Arrangements were being made with external healthcare professionals to deliver additional training to support staff practice and any gaps in knowledge. The home manager told us training was planned on the Mental Capacity Act and its requirements and with the NHS Rapid Response Team.
● All staff had attended a supervision meeting (a planned meeting with a manager to discuss and review work progress, including learning and professional development needs) since September 2019.
● The skills and experience required by the home were considered when recruiting new staff. Arrangements were underway to employ a new clinical lead to support and provide leadership to nurses and care staff.
● The home manager told us they had contacted a hospice and arrangements were going to made, for training in end of life care.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Arrangements were in place for people to be reviewed by a GP or the out of hours GP service when needed. Community nurses visited to support people's health needs.
● A lack of co-ordinated care and communication between staff had sometimes caused delay in people accessing the support of external healthcare professionals. The risk of this had been reduced since the employment of a unit lead who now predominantly took responsibility for liaising with healthcare professionals. This would be further supported when the clinical lead started in post.
● Arrangements still needed to be completed for more regular planned support from GPs, NHS dentists and opticians.

Supporting people to eat and drink enough to maintain a balanced diet
● People's views on the quality and choice of food varied. Comments included "The food is very good", "The food is fantastic" and "Well it is variable. I try to be measured in my view, so, not too bad today, but the soup

yesterday was not good at all."

● People received support to eat and drink enough. Water jugs were delivered to people's bedrooms and replenished twice daily. Arrangements had been made to provide additional support to the care floors at mealtimes.

● People had access to and were provided with snacks and drinks in-between meals.

● People were supported to make choices about what they ate and drank.

● Specific dietary preferences were accommodated and the needs of people with more complex dietary needs were met.

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

● Adaptions had been made to the service to meet people's needs which included a call bell system so people could summon help, keypad security to care floors and lift (on one floor) and non-slip decking to outside balcony areas.

● Further thought had been given to the furniture in communal lounges as more people used the service to ensure there was enough seating, suitable for people to use. Sofas provided in these areas were low and did not always meet people's needs.

● Communal toilet doors were wide and able to accommodate wheelchairs or hoists, however, they opened outwards into the hallways and could be a potential risk to people walking by. We fed back our observation on this to managers, so they could consider and manage any potential risk associated with this.

Good

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 remained Good. This meant people were 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

- Work had started on gathering more information about people's life histories, backgrounds and preferences to support a more person-centred approach to care.
- One person said, "We are looked after well" and another person told us "The staff are all very sweet and helpful." One relative who had concerns about how their relative's health was managed told us that despite this, "The care staff are always very kind."
- We observed staff treating people equally and with respect and dignity. This took place when staff supported people at mealtimes, when people became anxious and needed reassurance and, during simple interactions with people who lived with dementia.

Respecting and promoting people's privacy, dignity and independence

- One person was very clear about what areas of their care they wished to remain independent with and staff had respected this.
- There were arrangements to keep recorded information about people's care and treatment secure and private.
- People's privacy was maintained; staff knocked on people's doors before entering and all intimate personal care; washing, dressing and supporting people with their toilet needs was carried out behind closed doors.
- A relative of one person explained why it was so important for them to be able to leave their relative and know they were treated with respect, kindness and compassion. They explained their relative was totally reliant on care staff. They said, "[Name] sings their [the staffs'] praises and I feel blessed [name] is here. I see that [name's] clothes are always clean and that [name] never smells and is kept fresh and clean. I worry about bed sores, but I see staff reposition [name] regularly. I get uncomfortable about so many agency staff, but one spoke to me today and they were so kind. They [staff] are always coming in [to the bedroom] checking on [name] and offering a drink."
- People's independence was supported. Where safe to do so people could use the drink making facilities in the dining rooms and go out with family and friends when they chose to. We observed staff providing support to one person but also recognising when this person wanted to remain independent.

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

- Staff spoke with people in a way which people could understood helping them to make choices. They took time to repeat themselves if needed or rephrase what they had said when it was helpful to do so. Some staffs' communication skills were particularly good, and they took extra care to kneel or sit down next to

people so eye contact could be made and people could hear them.

● Staff listened to people's views and respected these for example, if they declined support or a suggestion made by the staff about their care or daily activities. We observed the same good practice from agency staff when they were supporting people to make choices.

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 ensure people have choice and control and to meet their needs and preferences

- Care plans had not been reviewed monthly as per the provider's requirements and varied in the detail they gave staff about people's needs and wishes. The majority reviewed during the inspection gave little detail about people's choices and preferences.
- We needed to ask staff about people's current care needs to be sure about what these were. In some cases, there had been no changes from that recorded in the care plans, but for others, the care plans did not fully reflect people's current care needs. The need for accurate and well-maintained care records was an area for improvement in the previous inspection.
- One person who lived with dementia had required additional support to ensure they ate and drank enough. In September 2019 their nutritional status was recorded as being 'variable with poor food intake.' There were no subsequent recorded entries about this in their care records and their weight had not been recorded since September 2019. Records showed that an agreement had been made with relatives to provide more regular support at mealtimes for this person. Despite a lack of recorded information about this, during the inspection, we observed support being provided to this person at mealtimes and staff told us the person was eating and drinking well.
- Information in line with guidance and the law was not always accurate. One person's record had 'yes' for DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) implying this person was not to be resuscitated however, there was no DNACPR order in the care file and one could not be found elsewhere. Their wishes might therefore not be acted on if an emergency was to occur.
- Another person's care had been agreed with the person's representatives and recorded in the staff diary. Their care plan had not been reviewed to ensure this additional care was recorded for staff guidance.
- Another person's representative told us they had wanted to know when their relative had last had a shower but had been unable to get this information from the staff. A member of staff told us the person washed themselves and they were sure another member of staff helped them to shower but the care records did not record this.
- Recorded staff hand-over records had been introduced, to help ensure staff had basic information about people's conditions and risks, however, during the inspection we found the process for making sure these records remained consistently up to date was not fully in place.
- We reviewed this person's care plans which made no reference to the person's end of life choices or wishes and did not record if these had been explored with them or not.

A lack of accurately maintained records, which included, health assessments, care plans and staff hand-over records, available for staff to reference, put people at risk of receiving inappropriate or unsafe care and treatment. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The home manager told us that work needed to be done to meet these standards fully, although if asked, information could be provided in different formats; large print, audio, easy read or different languages. This was therefore an area for improvement.

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
● Since September 2019 arrangements had been made to improve people's social opportunities and bring people together to avoid isolation.
● An activities co-ordinator was in place and they organised activities which people enjoyed taking part in. During the inspection we saw small groups of people enjoying quizzes, discussions and memory games led by this member of staff. A choir had been formed and people who lived in the home sang together, supported by regular visitors to the home. We saw that people had clearly enjoyed a choir session during the inspection including the chat with tea and cake afterwards.
● Links with community groups were being made to try and improve people's integration with the wider community. An example included contact with a military wives group. Links were also being made with schools and nurseries to support future intergenerational activities.
● Although people in their bedrooms were visited by the co-ordinator and care staff, more work was needed to provide these people with activities which were meaningful to them.
● People's relatives and friends were able to visit without restriction and their pets were welcomed.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy and procedure in place.
● A historical lack of proactive and effective management of areas of dissatisfaction and concern, raised predominantly by people's representatives, had led to formal complaints being made.
● The home manager shared with us how they had responded to some of the issues raised. This had been done in a timely way and where an immediate response had not been possible, an explanation had been given for this.
● Issues raised had been investigated and addressed and resolved where it had been possible to do this. Where a concern could not be substantiated this had been explained. Where issues had arisen from poor communication or poor management of a situation this had been acknowledged and the subsequent action taken to address this explained.
● However, some areas of dissatisfaction and complaint had not been fully resolved because necessary improvements to the quality of the service had either not been forthcoming or successfully implemented. Just prior to the inspection some representatives had escalated their dissatisfaction of the service to the provider. During the inspection period a representative of the provider met with them to hear what their issues were and to try and resolve these. We are unable to report on the outcome of this meeting in this report as the full outcome of this was unknown at the time. We will be following up actions from this in a separate meeting with representatives of the provider.

End of life care and support
● One person was receiving end of life care and they told us they were comfortable. We observed staff visiting this person to carry out checks on the treatment they were receiving and to offer the person reassurance and comfort.

● Information in line with best practice guidance regarding this person's care and treatment wishes in the event of needing emergency treatment was seen in their care file. This included a DNACPR order which had been discussed with them.
● Managers confirmed that local GPs and community nurses had been supportive when help with end of life care had been required.
● The home manager told us they had contacted a hospice and arrangements were going to made, for training in end of life care for the staff.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At the last inspection the provider had failed to operate effective quality monitoring systems to monitor and improve the quality of care people received. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider continued not to operate an effective quality monitoring system. They had failed to identify and address shortfalls in the service and we found this had impacted on the care people received.
● Following the last inspection, the provider sent the Care Quality Commission (CQC) their action plan outlining the improvements they would make to address the shortfalls we found at our previous inspection. During this inspection we found they had failed to monitor the progress of this plan and subsequent updates of this and necessary improvement actions had not always been carried out and sustained. This included effective assessment of people's risks and continued review of people's risk assessments and care plans. Despite us being told these should have been reviewed at least monthly we found one person's moving, and handling assessment and pressure ulcer prevention risk assessment had not been reviewed since July 2019. All other risk assessments and care plans inspected had ceased to be reviewed after September 2019. Improvements recorded in the service improvement plan, in relation to requirements in line with the Mental Capacity Act 2005, had not been sustained as similar shortfalls identified in the previous inspection were identified during this inspection.
● Following the last inspection, the provider had not effectively monitored the quality of the service and did not take timely action when they did identify concerns. Concerns were raised with the provider in April 2019 and in June/July 2019 representatives of the provider found discrepancies in the information being forwarded to them from the service. Concerns were also confirmed when they visited the service in July 2019. However, there had been a delay in taking action and it was not until late August 2019 that action was taken to start addressing the issues identified and reduce risks to people. During this inspection we found risks to people had still not been fully reduced.
● In August 2019 managers had found that the provider's program of service-based audits had not been completed. We also found care plan audits had only started in September 2019 and work to improve care

plans had just begun in late October/November 2019. The provider's audit program was in its infancy during the inspection and sustained completion of this, leading to sustained improvement still needed to be demonstrated. Other audits, which formed part of the provider's quality monitoring program, had been allocated to other staff and as above, this process was in its infancy and needed to be sustained for the service to be effectively monitored.

● Leadership of the care staff and co-ordination and monitoring of people's care required improvement. This was evidenced when inspectors had to highlight twice that the deployment of staff might not be effective before enough action was taken. Also, on the second day, inspectors highlighted a shortfall in accurate information available for staff in respect of one person's choking risk. Some action to address this was taken immediately but on the third day, when inspectors revisited this, this action had still not been fully implemented and it took inspectors to point out where the shortfall remained.

● This lack of oversight also impacted on the home's ability to ensure records relating to people's care remained accurate and effective communication was consistently maintained with people's representatives and visiting healthcare professionals. In some cases, this had caused unnecessary anxiety and upset to people's representatives and relatives. One relative said, "They [staff] don't really update me about [name's] care." This relative, along with others, told us they struggled to find the right member of staff to speak with and that information often differed depending on who they spoke with.

Systems were either not in place or robust enough to demonstrate good governance. This placed people at risk of harm. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Once in place the new home manager had prioritised their actions and had focused on addressing high risk areas first. These had included completing missing recruitment checks on staff already employed and delivering care to people. Staffing numbers were increased and staff absences and leave which had not been previously managed appropriately were addressed. An increase in the use of agency staff had been needed to support this. By the time of the inspection, although staff retention and staff recruitment remained a challenge, successful staff recruitment, which included the recruitment of a clinical lead, was taking place and managers were positive about being able to maintain a more stable workforce.

● A medicines, nutrition and infection control audit had also been completed when the current home manager had arrived in the home.

● Increased monitoring of the service was to continue by the Nominated Individual and a program of regular visits by the provider's quality monitoring consultant were planned.

● Although we were informed during the inspection that the home manager intended to apply to register to with the Care Quality Commission as registered manager of the service, at the time of the inspection were had not received an application in respect of this.

Continuous learning and improving care

● Managers acknowledged the shortfalls in their quality monitoring of the service and in the delays taken to identify and act on shortfalls. Information has been forwarded to the CQC explaining how representatives of the provider intend to ensure the service is effectively monitored moving forward. We will review the providers more detailed plan on this when we meet with them to discuss their progress.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The action being taken by managers to improve the service was aimed at promoting a more open, inclusive and person-centred culture. This was inclusive of people's protected characteristics such as age,

disability and cultural and religious preferences. This work however needed to be successfully sustained.
● Senior provider staff, including the home manager were visible and people, their representatives and visiting professionals had access to them. We observed this throughout the inspection. A more open-door policy had also been adopted.
● Relatives told us they did not always feel included in people's care decisions. Meetings with people's representatives were taking place to try to improve communication and resolve historical and current areas of concern and dissatisfaction. A program of regular meetings with people and their representatives was planned and needed to be sustained.
● A staff meeting was held which was reported to us as having been positive on both sides (staff and management) where managers listened to staff views and explained to the staff the actions being taken to improve the service moving forward. A program of regular staff meetings was also planned and needed to be sustained.
● A program of care review meetings, the improvements in people's opportunities to take part in activities and social gatherings and the additional support provided by non-care staff at lunchtime and supper time supported a more person-centred approach to care.

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
● There had not been an incident where duty of candour had applied.
● There had been examples of where staff had not effectively communicated with people and their representatives when things had not gone to plan or had not been carried out as they should have been. Action was being taken to improve staffs' communication with people and their representatives in such situations.

Working in partnership with others
● The service worked with local commissioners of care to facilitate admissions to the home.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was not a consistent process in place to demonstrate that appropriate consent from people or their representatives had always been sought and, that where it could not be demonstrated that consent had been provided, that where necessary, requirements of the Mental Capacity Act 2005 and associated code of practice had always been followed. Regulation 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not always been sufficiently assessed to ensure that all reasonably practicable steps were taken to mitigate or reduce such risks. Care and treatment had not always been delivered in a safe way. Regulation 12 (1) (2) (a) (b)

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes had not been consistently established and operated to secure compliance with all necessary regulations. The provider had not operated effective quality monitoring systems to enable them to assess, monitor and improve the quality of services provided. Accurate and complete records relating to the assessment, delivery and planning of people's care and treatment, including decisions made in relation to this, had not been fully maintained Regulation 17 (1) (2) (a) (b) (c).

The enforcement action we took:

We issued a warning notice telling the provider they needed to make the required improvements to meet the requirements of the regulation by 31 March 2020.