Nutten Stoven Residential Home

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
Nutten Stoven Residential Home is a care home providing personal care to up to 30 people. The service provides care to older people and people living with dementia. At the time of our inspection there were 21 people using the service.

People's experience of using this service and what we found
There was no effective process in place to ensure people were protected from the risk of abuse, and staff were not always trained in safeguarding. People did not always have the means to call for assistance and risk management was poor. People were not always supported by enough staff and safe recruitment checks were not always fully completed.

People's 'as and when' medicines were poorly managed, and we observed people to be in significant pain due to poor pain management. Staff administering medicines were not aware 1 person had epilepsy and they received a prescribed medication to treat this condition.

People, staff and visitors were not protected from the risk of the spread of infectious diseases, due to poor infection prevention and control.

People's needs were not fully assessed to ensure care was appropriate for their needs and they were not always supported by well trained and competent staff.

People were not always referred to relevant healthcare professional when needed and the provider failed to ensure advice and guidance from healthcare professionals was followed. People's relatives were concerned about their family members losing weight, and we found people were not always supported with their meals.

No menus were displayed during mealtimes and the provider had failed to ensure call buzzers were consistently in place and working correctly. The home was generally in good state of repair with reasonable decoration.

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.

There was a lack of opportunity for people to express their views they were not always involved in making decisions about their care.

People's protected characteristics under the Equalities Act 2010 were not always identified during care assessments or considered when planning their care. Feedback from people using the service was mixed, in

relation to how staff spoke to them. People's privacy and dignity was considered during personal care.

There was a lack of assessment processes to ensure care was appropriate for people's changing needs and people's relatives were not always included in planning their care.

There was a lack of signage throughout the service to direct people living with dementia, and multiple clocks displayed the incorrect time. There was a lack of daily activities to promote task engagement or social inclusion.

Complaints were not always adequately responded to in a timely manner and 1relative told us they found it difficult to contact staff at the home to raise concerns.

There was a lack of guidance available for care staff in relation to people's end of life care needs and staff had not received training on end of life care and some staff lacked knowledge in this area.

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 9 September 2022) and there were breaches in regulations. 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 the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. The provider has taken action to mitigate the most urgent risks identified, and this has been effective.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to safety, protecting people from abuse, leadership and staffing. We imposed conditions on the providers registration and requested the provider make immediate improvements at the service to improve care and reduce risk. Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective. Details are in our effective findings below.	**Inadequate**
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**

Nutten Stoven Residential Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection of the care home was completed by 1 inspector. A second inspector supported remotely by speaking with staff and relatives via telephone.

Service and service type
Nutten Stoven Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Nutten Stoven Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection

The first inspection visit on 01 November 2022 was unannounced. We gave the provider 24 hours' notice of the second and third inspection visits on 02 and 03 November 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 2 relatives, to learn about their experiences of the service provided. We spoke with 10 staff members including the provider. We also received feedback from one health and social care professional who knew the service.

We reviewed a selection of care records for 8 people including medicine administration records, care plans, risk assessments, daily notes and incident forms. We reviewed 4 staff files and records relating to training, recruitment, performance management and support.

We reviewed a selection of records relating to the management and quality monitoring of the service. These included complaint management, accident and incident monitoring, quality audits, meeting minutes and provider oversight. We also reviewed a selection of policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected by an effective safeguarding system. There was no process in place to record safeguarding concerns or required follow up action. This left people at risk of harm. For example, concerns were raised regarding inappropriate care by a member of care staff. The provider failed to take swift action to investigate these concerns and ensure people's safety. In addition, there was a breakdown in communication between staff at the service, leading to delayed referrals to health professionals. This meant people were exposed to ongoing risk of harm.
- Staff were not always trained in safeguarding. Some staff lacked knowledge on identifying and reporting concerns. This meant the provider could not be assured staff were keeping people safe.
- Feedback from healthcare professionals indicated people's safety was not always maintained by the provider. One healthcare professional stated staff were not responding to concerns in relation to the incorrect use of pressure relieving equipment and care remained unsafe. We observed staff were not always responsive to concerns raised by healthcare professionals.

The provider failed to ensure people were protected by an effective safeguarding system. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite identified concerns, people told us they felt safe at the service and were comfortable raising concerns. One person said, "I would tell senior staff if I had concerns, I would feel comfortable raising concerns to staff".

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection, we found people were at risk due to poor risk management, unsafe medicine practices and a lack of effective infection prevention and control. In addition, we found the provider failed to learn lessons when things went wrong. This was a 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.

- People were exposed to potential risk of harm due to poor risk management. For example, risk

management in relation to the development of pressure injuries was poor, and we found care was not always appropriate for people's needs. People's risk assessments and care plans in relation to the development of pressure injuries were sometimes blank or did not contain essential information about their care needs. One person had developed multiple pressure injuries since living at the service. We were not assured staff had relevant guidance to safely care for people's needs.

● Staff at the service, including management, were not always knowledgeable about risks related to people's care needs. We found staff lacked knowledge on 1 person's epileptic care needs, despite this information being available in the person's care plans. This person was at risk of not having their epilepsy care needs met, and at risk of potential harm in the event of an epileptic seizure.

● Healthcare checks were not always completed. In response to concerns raised by the local authority, the provider had recently put a system in place to monitor people's daily care. This included turn charts to monitor people who required repositioning in bed, and daily food and fluid intake records. However, these checks were not always completed by care staff. This put people at risk of not receiving essential daily care. After the inspection, the provider and the local authority reported improvements in this area.

● People were not always protected from the risk of falls. One person required the use of a sensor mat to alert staff when they mobilised independently. However, we found the mat not to be in use. Therefore, the person was not protected from the risk of falls.

● Assessment tools were not used effectively. For example, the provider used a malnutritional universal screening tool (MUST) to asses people's needs in relation to diet and maintaining a healthy weight. However, these tools were not completed or kept up to date. Therefore, the provider could not be assured people's needs were fully assessed.

● People did not always have the means to call for assistance. We found 1 person alone in their room requiring support, but unable to alert staff as they had not been provided with a call bell. This person told us they had to wait for staff to walk past their room to get their attention. We raised this concern with the provider, and they told us they had taken action to ensure people had the means to call for assistance. However, after the inspection, we received information from a healthcare professional that another person was left with a broken call bell and was unable to get the attention of care staff. This meant the provider had not ensured sustained improvement and people remained at risk of being left without the means to call for assistance.

Using medicines safely

● People's 'as and when' medicines were poorly managed. We observed 1 person experiencing significant pain during routine treatment from community nurses, as staff had not administered prescribed pre-emptive pain relief. There was no guidance available for staff in relation to pain management as the provider had not ensured care plans and medicine protocols were up to date.

● Medicine records were poorly managed. Medicine administration records were not always completed, and there was a lack of follow up action taken by staff to ensure people had received their medicines as prescribed. We found incidents where people had not received their prescribed medicines. This meant people were at risk of poor health due to not receiving their medicines as prescribed.

● Staff were not always aware of reasons for the administration of medicines. One person was prescribed medicine to treat epilepsy. Staff administering medicines were not aware this person had been diagnosed with epilepsy or that they received a prescribed medicine to treat this condition.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. The inspector was misinformed about people living at the service who had tested positive for COVID-19. This

increased the risk of the spread of infection, as the inspector unknowingly interacted with people who had tested positive for COVID-19.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. The provider was not ensuring self-isolation measures outlined in their policy, in relation to COVID-19, were adhered to. This increased the risk of COVID-19 spreading through the service.
● We were not assured that the provider was admitting people safely to the service. Admission assessments were not completed; therefore, the provider could not be assured they had considered the risks of people bringing infectious diseases into the service.
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. The providers policy required staff to where gloves, apron and a face mask, when supporting people who were self-isolating due to a positive test result of COVID-19. We observed staff did not consistently follow this guidance.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was a lack of signage and information available to make visitors aware of potential risks relating to infectious diseases. For example, there were no signs outside people's bedrooms when they were self-isolating due to testing positive for COVID-19.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The providers system for monitoring positive cases of COVID-19 was not effective.
● We were somewhat assured that the provider's infection prevention and control policy was up to date. However, this was not consistently adhered to by staff and the management team. We found the management team lacked knowledge on the providers policy, in relation to self-isolation periods, and had to refer to this during the inspection.

These issues constitute a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People were not always supported by enough staff. We observed 1 person try to get the attention of staff for 14 minutes before staff acknowledged them. During this time staff had walked past the person in a hurry. Multiple people felt there was not enough staff. One person told us, "they [staff] are very busy. I think there could be more."
● The provider used a dependency tool to assess required staffing levels. However, the provider had failed to ensure people's care needs were adequately assessed. This meant the providers dependency assessment was not correctly informed by the needs of people living at the service. Therefore, the provider was unable to make an accurate assessment of suitable staffing numbers. Care staff told us they were often very busy trying to meet the needs all residents, we observed this to be the case.
● Some scheduled staff were unable to work during the inspection. The provider was unable to find immediate cover as they had staffing vacancies. This impacted the staffing levels during our inspection visits.

People were not always supported by enough staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was taking reasonable steps to employ more staff.
● Safe recruitment processes were in place; however, we found some gaps in staff records. For example, the provider had not always recorded full employment histories and there were insufficient identification documents present for 1 staff member. This meant the provider could not be assured staff were always

safely recruited or suitable for their role.

Visiting in care homes

- The provider facilitated visits from health and social care professionals and people's relatives.

Inadequate

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were not always supported by well trained staff. New staff had not completed training identified by the provider as mandatory. For example, 1 staff member had not completed Health and Safety, Safeguarding or Infection Prevention and Control training. Some people had been identified to be at risk of choking due to specific swallowing difficulties. However, staff had not received training in this area and lacked knowledge on how to identify people at risk of choking.
- Staff working in the kitchen had not always completed food hygiene or cross contamination training. We did not observe any unsafe practices in relation to the preparation of food. However, without relevant training, the provider could not be assured staff had the required knowledge to minimise the risk of food poisoning or the spread of infectious diseases when preparing food and drink.
- People were not always supported by competent staff. There were no competency checks in place to ensure care staff had the necessary skills and knowledge. For example, staff competency was not assessed in relation to administering medicines and assisting people to move. This meant the provider could not be assured staff were delivering safe care.
- There was a staff induction process in place, however, not all staff had fully completed this. For example, staff had not always read or understood the providers policies and procedures before supporting people with care, as outlined in the providers induction checklist.

People were not always supported by well trained and competent staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider failed to ensure lawful authority was obtained when people were deprived of their liberty. We found deprivation of liberty applications were not always up to date. In addition, we found mental capacity assessments were not always completed or up to date. For example, one person was restricted to their bed through the use of bed rails due to poor mobility. However, no capacity assessment or deprivation of liberty application had been completed despite this person presenting a memory impairment. This meant the provider could not be assured people were supported in the least restrictive way possible.

The provider failed to ensure lawful authority was obtained when people were deprived of their liberty. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always fully assessed before they moved to the service. Preadmission assessments were not always fully completed and failed to identify people's essential care needs.
● When people returned to the service from an admission to hospital, their care needs were not reassessed. This meant the provider could not be assured care was appropriate for people's changing needs. We found people's care plans did not reflect people's needs following hospital admissions and care was sometimes unsafe.
● There was a lack of guidance available for staff and they were not always aware of people's personal choices or protected characteristics. For example, care staff were not always aware of people's diagnosis of dementia.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
● Advice and guidance from healthcare professionals in relation to people's care needs was not always followed. We found the provider had failed to ensure concerns and advice raised by healthcare professionals was followed. For example, in relation to the improper use of pressure reliving equipment and use of pain medicines, as reported in key question Safe.
● People were not always referred to relevant healthcare professionals when needed. Advice and support had not been sought from speech and language therapists to ensure people's needs in relation to chewing and swallowing food and fluids were safely managed. We found people were at risk of choking. This exposed people to risk of harm as staff did not have guidance on how to safely meet people's needs.
● People's relatives were concerned about their family members losing weight. The provider monitored people's weight, however, as reported in key question safe, the provider failed to ensure people's malnutritional universal screening tools (MUST) and food and fluid charts were kept up to date. This meant the provider could not be assured people were always getting enough food and drink.
● People were not always supported with their meals as needed. One person's care plan stated they required observation and prompts during mealtimes. However, we found the person alone in their room, with their meal on the table in front of them going cold.
● Opportunities to stimulate appetite were missed. There were no menus displayed at the service, and

people told us they were unaware of what they were having at mealtimes.
● We received mixed feedback regarding the quality of the food. One person told us they had bacon and egg for their breakfast and seemed to really enjoy this. However, one relative told us the food was of poor quality. The provider told us they were employing a new chef to support their team.
● During the time of the inspection, people's meals were provided by external caterers, due to kitchen staff shortages. The provider told us they were in the process of hiring a new chef.

Adapting service, design, decoration to meet people's needs
● There was a lack of signage throughout the service to direct people living with dementia, and multiple clocks displayed the incorrect time. This meant the environment was not always tailored for people living with memory impairments.
● The service was generally in good state of repair with reasonable decoration. This provided people with a comfortable living environment.

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

Supporting people to express their views and be involved in making decisions about their care
● There was a lack of opportunity for people to express their views or to provide input on the running of the service. We found no resident meetings took place and people were not aware of how to provide feedback.
● People were not always involved in making decisions about their care. We found care reviews sometimes took place without involvement from the person or family members. This meant people may not have received care in a way they were comfortable with.

Ensuring people are well treated and supported; respecting equality and diversity. Respecting and promoting people's privacy, dignity and independence
● People's protected characteristics under the Equalities Act 2010 were not always identified as part of their assessments. For example, preadmission assessments did not consistently record gender, sexuality, disability or ethnic origin. This meant how care was delivered did not always consider people's specific needs.
● People with sensory impairments were exposed to the risk of social isolation. Care staff told us 1 person with visual impairment spent most of their time in their private bedroom because they didn't feel comfortable moving through the service or eating in the dining room. There was no evidence the service had considered how to make the environment more accessible for this person to promote their independence and confidence.

The provider failed ensure care and treatment was tailored to people's individual needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed some care staff communicating with people in a kind and caring manner. However, feedback from people using the service was mixed. One person told us, "Sometimes they [staff] are a bit sharp. They [staff] expect me to know things when I don't." Another person told us, "Staff are friendly and caring."
● People's privacy and dignity was considered during personal care. We observed staff closing bedroom doors and curtains before supporting people with personal care.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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 was not always adapted to people's changing needs. For example, 1 person's care needs had changed considerably after a hospital admission. We found care was no longer appropriate for their needs and their care plan had not been updated to ensure staff had access to relevant guidance.
- People and their relatives were not always included in planning their care. There was minimal documented evidence to indicate the provider had sought information from people's relatives about their care needs and personal preferences to inform care planning processes. One relative told us, "I've no idea if he [person] has got a care plan."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- There was a risk of people being unable to independently navigate the service. Some people were living with dementia, and there was a lack of signage to direct them around the building, including missing names and pictures from their private bedrooms.
- Multiple clocks at the service displayed the incorrect time. We observed staff using these clocks to inform people of the time. This created confusion for people using the service wanting to know when lunch would be served.
- The provider failed to ensure people with sensory impairments were kept informed about changes to the service. We spoke with 1 person who was visually impaired. They told us they were not kept informed about changes to the service and had not been invited to provide feedback.

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 exposed to the risk of social isolation. People with high support needs were sometimes isolated in bedrooms at the end of corridors and received minimal engagement from staff. The provider acknowledged these concerns and stated their intentions to relocate people within the service based on

their needs, to better enable staff to provide regular engagement.
● 1 person told us staff support them to keep in contact with their relatives using the service phone. However, they told us they found this difficult when isolating due to COVID-19 as the phone line was often busy. There was a lack of alternative communication methods to ensure people could remain in contact with their relatives.
● There was a lack of daily activities to promote task engagement or social inclusion. The provider told us they had appointed an activities coordinator, however, during our 3-day inspection, we only observed 1-person independently engaging in a colouring activity. Other residents were sitting in the lounge or watching TV in their private bedrooms.

End of life care and support
● The service did not always engage people in planning their end of life care. There was no evidence that some peoples' needs for end of life care had been considered. This meant people's wishes and choices were not always known, therefore, the provider did not ensure people's end of life care was appropriate.
● End of life care plans were not always in place. There was a lack of guidance available for care staff in relation to people's end of life care needs or wishes as care plans did not always detail this information. After the inspection the interim manager told us they had taken action to improve end of life care planning.
● No staff had received training on end of life care, and we found some staff lacked knowledge in this area. This meant people were at risk of receiving inappropriate or unsafe end of life care.

There was a lack of needs assessment processes and the provider failed to ensure relevant people were informed or involved in planning people's care. Care was not always appropriate for people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Complaints were not always adequately responded to in a timely manner. For example, complaints about staff performance issues were not always dealt with promptly. This meant that people were exposed to poor quality care for prolonged periods.
● There was no oversight of complaints or concerns to determine possible themes. This resulted in missed opportunities to take targeted responsive action to ensure people received safe and appropriate care.
● People living at the service were not aware who the manager was or how to raise formal complaints. 1 relative told us they found it difficult to contact staff at the service to raise concerns. This meant staff and the provider were not always made aware of concerns and unable to take remedial action.

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained 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.

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

At our last inspection, the provider failed to ensure effective quality monitoring systems were in place and risk oversight was poor. The provider failed to promote a positive culture by ensuring documentation was used to inform care practices, and staff were not given opportunity to provide feedback. 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.

● Systems and processes were not effective. The provider had put in place additional documentation systems since our last inspection to monitor people's care. However, we found these were not always completed by staff in a timely way. For example, we found some daily note entries to be missing, and key information about people's care was sometimes not included. This meant the provider had failed to ensure these systems were effective.
● Guidance within the provider's policy and procedures was not always acted on or implemented into practice. Particularly in relation to infection prevention and control (IPC) and the assessments of people's needs. For example, needs assessments were not always completed, and IPC guidelines within the providers' policy were not always followed, in relation to the use of PPE or self-isolation periods.
● Important information was not always shared with people living at the service. For example, people told us they did not know who was running the service, what they were having for dinner or when resident meetings would be taking place. The provider told us they intended to have resident meetings moving forward.
● The provider's systems and processes failed to ensure staff conduct and performance issues were addressed in a timely way. We observed a delay in issues being addressed with individual staff, leading to prolonged periods of poor staff conduct.
● Staff supervision meetings were not completed in-line with the provider's policy. There was a lack of opportunity for staff to raise concerns or communicate with the provider. The provider has employed 2

interim managers and submitted an action plan, identifying this as an area for improvement.
● Quality assurance processes were not always effective. Care plan audits were not always completed and did not always identify incorrect or missing information within people's care plans. We found care provided often did not reflect what was written in people's care plans. In addition, medicine audits did not always identify medicine errors, and there was no indication identified actions were completed. This meant the provider had failed to ensure audits and checks were effective at improving quality of service.
● Staff were not always fully aware of their roles and responsibilities. Staff did not always understand their duty of care to safeguard people using the service. Some staff did not always know how to identify concerns regarding people's care and when to report concerns to health professionals. The providers induction procedures had failed to ensure staff were aware of these essential duties.
● Risk oversight was lacking. There was a lack of an effective systems in place to ensure risk oversight in relation to people's specific health and care needs. For example, systems and processes for assessing risk of pressure damage were not effective and care plans were not kept up to date. We found people to be at risk of pressure related injury. A lack of risk oversight meant the provider could not be assured risk was sufficiently mitigated.
● The provider continued to lack oversight of the service. This led to missed opportunities to improve the service. The provider acknowledged their continued lack of oversight contributed to the failures within the service.

Working in partnership with others
● The provider failed to ensure advice from health and social care professionals was acted on. This directly impacted people's care. For example, staff did not reposition people within the time frames specified by healthcare professionals or use pressure relieving equipment correctly. As a result, the provider failed to ensure care was appropriate for people's needs.
● Senior staff and management failed to act on concerns raised during the inspection. The inspector raised concerns regarding potential choking risks. These concerns were not addressed in a timely way by the senior staff and the provider had not followed up to ensure action was taken.

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 was no system in place for logging and reporting incidents. This meant the provider could not ensure effective oversight and complete any analysis to identify areas requiring improved safety.

The provider failed to ensure advice from health and social care professionals was acted on and there was no system in place for logging and reporting incidents.
These issues were a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was open and honest during the inspection about challenges and shortcomings at the service. Since the inspection the provider has taken action to improve quality of service.
● There was no registered manager in place at the time of the inspection. The provider was taking reasonable steps to employ a new registered manager and had a part time interim manager in place at the time of the inspection. Following the inspection, the provider recruited a second part time interim manager to support with service improvements.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed ensure care and treatment was tailored to people's individual needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure lawful authority was obtained when people were deprived of their liberty. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 People were exposed to potential risk of choking or developing pressure injuries, as the provider had failed to ensure people's care needs were adequately assessed and care staff had access to relevant guidance. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent Imposition of Conditions on Providers Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure concerns relating to people's care and safety were responded to in a timely way. There was a lack of service oversight and governance systems were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent Imposition of Conditions on Providers Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always supported by well trained and competent staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent Imposition of Conditions on Providers Registration