Milkwood Care Ltd

Chatterwood Nursing Home

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

Summary of findings

Overall summary

About the service
Chatterwood Nursing Home is a residential care home providing personal and nursing care to 34 people aged 65 and over at the time of the inspection. The service can support up to 37 people.

People's experience of using this service and what we found
People were not always protected against the risk of harm. Unexplained injuries were not always reported or investigated. Assessment of risks for people were not always completed effectively, mitigation plans were not implemented, and staff did not always follow care plans. Processes to ensure people were supported by suitable staff were not always operated. Risks posed by the environment were not managed effectively.

People's health was not always monitored effectively and guidance from healthcare professionals was not always requested in a timely way. People did not consistently receive personalised care. People told us they were involved in making decisions about their care, but where people may have difficulty communicating decisions, they were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible and in their best interests. The provider had not ensured that staff received robust induction to the service or had access to the training they needed to be able to support people effectively, based on people's needs. Staff practice demonstrated people were not consistently treated with dignity and respect.

The provider's systems for monitoring and improving the quality of the service had not been effective, because people were not always receiving a good quality of service and risks had not been mitigated. Systems were not in place to allow continuous learning and improving care. There was not a robust process in place to monitor, act upon and analyse incidents, accidents and near misses. The placed people at continued risk of harm.

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

Rating at last inspection.
The last rating for this service was Good (last report published 14 January 2017).

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

Enforcement
We have identified breaches in relation to safe care and treatment, gaining consent, staff training and support, treating people with dignity and respect and governance systems.

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

Follow up
We will continue to monitor information we receive about the service. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
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**

Chatterwood Nursing 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 Care Act 2014.

Inspection team
The inspection team consisted of two inspectors, a specialist nursing advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Notice of inspection
This inspection was unannounced.

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

During the inspection

We spoke with eight people who used the service and five relatives about their experience of the care provided. We spoke with 12 members of staff including the provider, registered manager, care workers and registered nurses, as well as ancillary staff. Some people using the service were not able to verbally express their views about the service. Therefore, we spent time observing interactions between staff and people.

We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

• Everyone told us they felt safe living at Chatterwood Nursing Home. Comments included, "We are safe here, it is good to know that someone is looking after you to make sure that you are well day and night", "Oh absolutely, I feel safe and happy in this place. All the staff are hard-working and very kind to me – I guess that applies to all of us here" and "I don't think I would like to go anywhere else because I am happy and well looked after here".
• Although the feedback we received was consistently positive our findings did not demonstrate people were always receiving care that kept them safe and free from harm.

Systems and processes to safeguard people from the risk of abuse;
• Although staff were able to talk to us about safeguarding, what to look for and how to report concerns, our observations and discussions with staff suggested they did not have a complete understanding of protecting people from harm.
• During the inspection we heard one person shouting out and saying "Get off me" and "Stop". This person was being given personal care. This was causing them distress and they were not agreeing to the care. Despite this staff continued. Throughout the person's care records it stated that if they were resistant to care being delivered they should be left alone for a while and staff should try again later. When we spoke to staff about this they responded poorly, shrugging their shoulders and one member of staff said, "Well [the person] is pooey".
• Staff had failed to recognise the distress being caused and had failed to consider alternatives.
• Following the care intervention and staff leaving this person alone, they continued to be distressed. We spoke with this person calmly and asked if they wanted some music on and a drink. They said yes and calmed instantly. We observed bruising on this person's forearms but found no records to explain where this had come form or that it had been investigated. A nurse was not able to explain the bruises and told us that not all bruising would be documented on body maps or incidents records. They said not all bruising would not be investigated unless it looked like a hand or finger print.
• We fed this back to the registered manager and nominated individual who agreed this was not acceptable.
• We found a further two people had unexplained injuries and no records to demonstrate these had been recognised or investigated.
• A failure to recognise possible abuse, a lack of reporting, records and investigation into unexplained injuries meaning people were at risk of recurring harm because the cause of the injuries had not been established.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

• We referred our concerns to the local authority responsible for safeguarding.

Assessing risk, safety monitoring and management
• People were not always protected against the risk of harm because assessment of risks for people were not always completed effectively, mitigation plans were not implemented, and staff did not always follow care plans.
• We heard one person shouting to staff to 'get off them', during their personal care. Staff continued to deliver personal care and the registered manager told us this was a known behaviour for this person and had been agreed in their best interests. We found no records to confirm this.
• There was no assessment of the behaviours this person could display. There was no plan in place to minimise the risk of these presenting and to manage them in the least restrictive way possible if they did arise.
• We found one person was using bed rails. These are rails attached to the side of a bed to reduce the risk of rolling, slipping, sliding or falling out of bed. The use of bed rails can pose a risk of entrapment and injury. To reduce this risk bumpers placed over the rails are used. Although the use of bed rails had been assessed for this person, it was unclear why these were in place as they confirmed the person did not have a history of falling from bed. The assessment confirmed no other measures had been considered and that the use of bumpers had been assessed but no outcome of this assessment had been recorded.
• On the side where there was no bumper in place we noted an injury on this person's hand. A nurse told us they did not know about this person's injury and there were no records of this. They also told us there was no reason why a bumper should not be on the bed rail. The risk assessment stated that the person had been assessed for the use of bumpers but did not confirm what was required. A failure to effectively assess the use of bed rails as well as a lack of reporting of the injury and a lack of investigation meant we could not be confident the injury was not caused by the use of this piece of equipment.
• We found risks to people from loose or damaged electrical fittings in the two bedrooms. These risks had not been identified despite room risks assessment having been conducted and last reviewed two days prior to our inspection. Following the inspection we were informed these had been fixed.

A failure to ensure risks were assessed and plans implemented to reduce risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Staffing and recruitment
• Although potential new staff were required to complete an application form, attend an interview and provide references it was not always clear that the provider adhered to their own recruitment policies to ensure people employed were of good character and safe to work with vulnerable adults.
• For example, four of six staff records we looked at only contained one reference. The providers policy stated that in these circumstances a risk assessment should be conducted however, there was no record of risk assessments having been completed.
• There was not always a clear record of an interview and notes taken by the registered manager did not reflect an assessment of character.
• One member of staff had a criminal conviction, but no risk assessment had been conducted to ensure any potential risks were assessed and plans implemented to reduce these.

A failure to operate recruitment procedure that ensured an effective assessment of a person's character was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• No one raised any concerns about staffing levels.

Using medicines safely
• Medicines were stored securely. The temperature of the medicine's storage was checked daily to ensure medicines were stored at the correct temperature; Medicines that required extra control by law, were stored securely and audited weekly.
• Accurate records were maintained of medicines received into the service, administered and disposed of. Medicine administration records (MAR) were completed as required.

Preventing and controlling infection
• The service managed the control and prevention of infection well.
• Staff had access to and used appropriate personal protective equipment.
• The home was clean, tidy and free from bad odours.

Learning lessons when things go wrong
• There was little evidence that when something went wrong the service used incidents as a learning opportunity. Incidents were not always reported and there was no evidence that incidents were investigated. A lack of investigation meant identifying where practice could be improved upon or developed was not possible.
• However, on discussion with the registered manager it was evident that some learning from the reporting of falls had taken place. Whilst there was no formal audit or analysis of falls, the registered manager had identified from a log of falls that the majority of these had been occurring during the evenings. As such they had sourced extra staff to remain in the communal area of the home between the period of 6pm to 10pm. We were told this had led to a reduction in the number of falls in the home.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Prior to moving into the service, the registered manager met with the person to ensure their needs could be met at Chatterwood Nursing Home.
• This assessment did not use any nationally recognised assessment tools such as Waterlow (a tool to assess the risk of skin breakdown), or Malnutrition Universal Screening Tool (a tool used to determine the risk of malnutrition) to determine risk levels of people. These were in place on a computerised care planning system used. However, for one person who had moved in on 3 July 2019, these had not been completed as the computer system was not working and no paper records were held.
• Following the inspection we were told that verbal information about this person's needs was provided to staff on the morning of our visit and that the handover sheet was updated that same day.
• Whilst the assessment asked about people's needs associated with any protected characteristic, this was not always completed.
• The registered manager and staff told us they were confident any equality and diversity needs would be met, and no discrimination would be tolerated. We saw no evidence that anyone who used the service was discriminated against and no one told us anything to contradict this.

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.

• Staff lacked an understanding of the MCA and records did not demonstrate this had been applied where needed.
• For example, the registered manager told us that one person did not like to be touched and became distressed during personal care, so they told us it had been decided to "Get [the person] done as quickly as possible in order to get [the person] up and downstairs as quickly as we can, [the person] then calms down".

• They told us a mental capacity assessment and best interests decision had been completed to decide on this approach. However, we found no records to confirm this. This person's care records stated that due to their diagnosis this may affect their capacity to make decisions. It also stated if the person did not provide consent to leave them for a while and return later.
• No time and decision specific assessment of capacity had been undertaken and we observed staff continued to deliver personal care despite the person clearly not consenting to this.
• We found the same statements documented in another person's care records regarding medicines management. Staff were managing and administering medicines for this person however, no consent was found, and no time and decision specific assessment of capacity had been undertaken.
• This person's consent section of their care records also stated that their family member had agreed to the use of photographs of this person and to their care plans. However, there was no evidence this person had legal authority to provide such consent.
• This meant people were receiving support that they had not consented to and that had not been agreed in their best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Where required, DoLS had been applied for, although at the time of our inspection only three had been authorised by the supervisory body. None of these had conditions attached to them.

Supporting people to eat and drink enough to maintain a balanced diet
• Throughout the inspection we identified a number of people who had lost weight or whose weight was very low. We found no evidence of how this was being effectively monitored and of the action being taken to ensure people did not become malnourished and develop further health complications.
• One person's records reflected a weight loss of 13.6 kg since January 2019. Their care plan identified a high risk of malnutrition but did not reflect the significant weight loss or that any other professionals had been made aware. We found no action had been taken to identify the cause of the weight loss and support the person to ensure risks were managed. Their care plan and the information in the kitchen indicated this person required support to eat their meal however we found this had not been provided. Despite being provided with a meal, two hours later this had not been eaten and no member of staff was present offering support and encouragement. No monitoring of this person's dietary intake was in place.
• We found another person had lost significant weight and whilst they had commenced food supplements, there was no evidence to suggest that their food intake was being monitored or that extra effort was put in place to encourage nutritional support.
• The registered manager told us no one in the home was having their food intake monitored.
• Increased monitoring of people's weight was not implemented when weight loss was a concern.
• Where people had been assessed as at high risk of malnutrition or had lost a significant amount of weight there was no evidence of Dietician involvement.

The failure to take all reasonably practicable action to mitigate risks to people from weight loss was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• People were confident in staff abilities to carry out their role. One person told us "I have every confidence in the staff. I feel that they do a great job in this place. I cannot tell you anything about their training, but I think that from what I see, they must have good training. They are excellent in what they do".
• Despite the positive feedback we received we found staff did not receive an induction to the service that ensured they were competent to meet the needs of people.
• The provider induction policy guided the manager to plan this for new staff however we saw this wasn't followed. Staff induction consisted of a period of shadowing other staff and ticking off a checklist of policies, environmental tour and issues and some expectations over two days. The registered manager confirmed no assessment of staff competence was undertaken, except in relation to medicines administration.
• The registered manager confirmed no plan was in place to ensure training needs were assessed and training booked during induction. We found two newer members of staff had completed no training since starting their roles in May and June 2019. A third member of staff had only completed training in Controls Of Substances Hazardous to Health (COSHH) since starting their employment in May 2019.
• We found staff were not provided with training they needed to be able to support people effectively, based on people's needs.
• Medicines were being administered by either a registered nurse or senior carers who stated that they had received medicines training and had their competencies checked annually. We saw that a tick box system had been used to assess the staff member's ability. This stated that staff would undertake rigorous, recognised training in the administration of medicines, however the registered manager confirmed no recognised training was provided. This meant staff administering medicines had not had training to do so safely.
• For example, we observed a poorly managed behavioural situation and found staff had received no training to support them to understand how to reduce the likelihood of behaviours occurring or effectively manage them should they occur.
• We observed a number of people had lost weight in the service and a lack of action being taken to ensure this did not cause additional risks and complications for people. Despite the providers policy stating that staff would be competent to monitor and assess for malnutrition and respond in a timely manner, no training had been provided to any staff about the management of nutritional needs and no competency assessments had been undertaken.
• We identified that staff practice did not always promote people's dignity or demonstrated respect for people. We have reported this is caring. No training had been provided to staff around dignity and respect and no competency assessments of staff practice had been completed.
• The registered manager told us there was no training plan in place outlining what staff needed to do and by when.
• The lack of training, assessment of staff competence combined with our observations demonstrated staff were not fully supported to undertake their role effectively.

A failure to ensure staff received appropriate training and assessment to ensure they were competent to deliver their role and meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

• Staff told us they felt supported and records confirmed they received supervisions.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Staff told us that handovers between staff occurred at the beginning of each shift where each person's care needs were discussed. The handover sheet used to guide staff lacked vital information. For example, one person had experienced a choking episode, but this was not on the handover. Another had a pressure sore

and this wasn't included. As the service also had not had access to the care records for anyone in the service for seven days at the time of our visit, knowledge of people's needs relied on staff memory. The lack of up to date information could mean people received inappropriate or unsafe care and treatment.
• Staff reported to have good relationship with external agencies. For example, Hospice services, Community Nursing Teams and local GP.

Adapting service, design, decoration to meet people's needs
• People were cared for in an environment which aimed to meet their needs. It was spacious and well lit. Rooms were laid out to enable people to understand the purpose of the room. For example, the dining room looked like a dining room with table laid with cutlery and condiments at meal times. Bedrooms were spacious, and people were able to personalise their rooms.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

• Feedback from people and relatives about the support provided was positive. Comments included; "The staff are so kind and caring to me. They are always there whenever I have needed them"; "They are really caring in every way you look at it. I don't know where I would be without them"; "They listen to me whenever I ask them for anything and respect anything I say to them"; "I feel that they respect my personal dignity and space and they treat me and my wife with kindness. They always respect what I say to them or if I want something done" and "They do encourage us to do things by ourselves".

• Whilst the feedback we received was positive we observed some practice that demonstrated people were not consistently treated with dignity and respect.

• On one occasion we found a person clearly agitated and requiring support with personal care. We were required to find a member of staff as no staff were present. When we asked the member of staff to help the person they replied by saying they would do so once they had taken their [staffs] dinner plates to the kitchen. We were required to inform the member of staff the persons need for care should take priority over taking empty plates in a staff room, to the kitchen.

• One a second occasion, despite needing support with their meals another person was left alone with their meal for two hours. Staff had entered this person's room on several occasions in this period of time, however there was nothing recorded to show they had offered support and the person finally ate their meal when it was cold. A member of staff did enter the room and hand the person a bowl of dessert then left. The person began to eat their meal but did spill some of this on their clothing and they had not been provided or offered a clothes protector. We also noted the member of staff documented that the person was awake and comfortable, however as the member of staff had not asked the person if they were comfortable before leaving the room, we could not identify how they had established this.

• In addition, we received feedback from some staff members that other staff members were not always respectful and caring in their approaches. One member of staff told us, "Some staff are abrupt, It's the manner they go in with and how some of the staff speak to people. Some people fail to say hello, sometimes staff just put food in peoples mouth and don't explain what people are having". A second member of staff told us, "sometimes staff shout at people. later, wait a minute sit down. Staff are stressed". Whilst the registered manager and provider told us they had been surprised by our feedback it was evident concerns about people not being treated with dignity and respect had been raised with them in the past. We found issues of a similar nature had been raised by relatives during meetings. For example, in one meeting we saw

feedback had been provided that staff had told a person they didn't have time to put their hearing aid in, that the tone of staff when talking to people was not professional and some staff needed to 'calm down and not be too quick when dealing with some residents'. We saw staff meeting minutes whereby issues of treating people with dignity and respect had been raised.

Our observations, staff comments and the meeting records demonstrated systematic concerns about staff practice being disrespectful and undignified. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
• People told us they were involved in making decisions about their care. One person said, "They do involve me in the decisions about my care. We have had meetings with them and they are so good to us". Another said, "They do listen to what I say to them and respect my decisions". A third person told us, "They wouldn't do anything for you and to you without seeking your opinion".
• The registered manager gave us an example of how they had involved a person, and relevant others to achieve a positive outcome for one person. They told us how they had worked with the person and local authority to ensure a married couple could live together at Chatterwood Nursing Home. They told us 'it was their 25th Wedding Anniversary this year we arranged with the vicar of the church where they got married to renew their vows. Most of the staff went and family and friends and they had an amazing day and a party at Chatterwood in the afternoon. To see the joy on their faces and the memory will live forever. We did them a photo album for them to keep forever".

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; End of Life Support

• People told us they had been involved in their care plans and that staff worked with them to make life better for them. One person told us, "Yes they talk to me about my care plan and any changes that may occur there, but I am not bothered as long as I am safe and cared for". A second person said, "Yes I talk to staff about my care needs and they work with me all the way to make life better for me and they look after me after me very well. They would not do anything without talking to me and I trust them.

• However, care records did not consistently reflect personalised care was planned and delivered. For example, a person who had suffered a number of falls did not have an updated risk assessment to reflect the increased risk of falling. They were prescribed medicine which could increase this risk and there was no evidence this had been reviewed. Whilst nursing staff were able to confirm the medicines were not being administered the records had not been updated to show this personal approach.

• Whilst we saw that appropriate equipment was in place to help manage potential skin integrity concerns, we could not see that staff always responded to advice given. For example, one person had been referred to a Tissue Viability Nurse (TVN) for specialist input in April 2019. The records indicated that the Home should have contacted the TVN if the wound hadn't improved. There was no evidence this had been done even though the pressure damage had remained the same.

• Staff were able to tell us how people's end of life care needs would be met, which reflected a holistic approach and ensured their preferences were considered.

• We saw that the service worked with a local hospice to deliver the six steps programme of end of life care, however, records did not demonstrate end of life care planning was considered in advance. For example, two people's records confirmed that they had been admitted for palliative care, meaning their condition could not be cured. However, their records stated that an end of life care plan was not required. This meant staff would not have access to appropriate guidance to meet these people's holistic needs when they reached the end of their life.

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 registered manager was aware of the need to support people's varying communication needs and told us that picture cards were used for one person. In addition, they told us boards to write on could be used

and one person was encouraged to sing their requests as they were able to communicate this way.

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
• We were told that a variety of activities with external entertainers was provided and people confirmed this. During the inspection a party was held for a staff member and we were told this was at the request of people who lived in the home.
• The registered manager told us how some relatives ran a knitting club and art club on a fortnightly basis and they had set up a group with the British Legion, were once a month a coffee, cake and a chat, with people from other surrounding homes took place.

Improving care quality in response to complaints or concerns
• People told us they had no complaints and if they did, they would discuss these with the registered manager and/or staff. They told us they were confident they would be listened to. One person said "If I needed help I would speak to the lovely carers here and the manager, but I have never had anything to complain about. I believe that they will listen to me".
• Records of complaints were maintained and reflected these had been managed appropriately and action taken to address them.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Governance systems failed significantly to protect people from the possibility of abuse or harm and were not effective in identifying areas for improvement. We found systematic failures to be widespread.
- Despite numerous registered manager and provider audits being undertaken, concerns about the safety and quality of the service had not been identified.
- Numerous policies were in place to guide the registered manager and staff, but these were not being applied in practice. For example, the care planning policy referred to staff being competent, but no training had been provided and no competency assessment undertaken. The recruitment policies referred to undertaking risk assessments if more than one reference could not be sought, however risk assessments had not been completed in these circumstances. The incident and accident policy were not being adhered to.
- Reviews of environmental risk assessments were being completed but had failed to identify environmental concerns that posed risks to people and as such no measures had been taken to ensure these were rectified.
- Concerns about the management of weight loss that we found had not been identified and action had not been taken to ensure people's safety and well-being.
- The lack of reporting and investigation of unexplained bruising had not been identified, putting people at increased risk of harm, of the service.
- The need to ensure staff training was in place to meet people's needs had not been identified.
- Concerns about a lack of person centred and disrespectful approaches by staff had been raised with the registered manager prior to our inspection but had not led to improvements. Staff had not been provided with training to help them understand the importance of person-centred care or the need for dignity and respect and no competency assessments of staff in this respect, had taken place. Processes to ensure improvements were made so that staff were working in a respectful and person-centred way had not been implemented.

A failure to operate effective systems and processes to ensure the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Whilst the registered manager and provider told us they were passionate about providing a person-centred service it was not always apparent that this was translated into care provided. For example, we saw staff failed to provide support to a person to ensure they ate their meal, staff continued to provide care to a person despite them not providing consent and becoming distressed. Staff had not recognising the need to provide support to a person that was agitated should be prioritised over removing a plate. Meeting minutes demonstrated that the registered manager had raised concerns with staff about their practice towards people on a number of occasions, but our observations demonstrated this had not led to necessary improvements.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• A senior member of staff was unable to tell us what Duty of Candour meant and how this applied to their day to day work.
• The registered manager told us there had been no incidents where Duty of Candour applied.
• However, systems to ensure that any possible incidents where duty of candour might apply were not being effectively implemented and monitored. For example, incidents and accidents were not always reported, recorded or investigated. A failure to report all incidents and undertake investigation where required meant we could not be assured the registered manager and the provider responded to concerns with openness and transparency.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider used a number of systems to engage with others including, meetings, surveys and an internet feedback system. We saw that feedback via surveys and the internet were positive with comments such as 'very satisfied with the care, the attention to detail, the high quality of nursing' being provided.

Working in partnership with others
• Staff had developed links to other resources in the community to support people's needs and preferences. These included the British Legion, a local hospice and local colleges.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had failed to ensure people were treated with dignity and respect at all times. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider to undertake certain activities and audits and to report to us on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure people were treated with dignity and respect at all times. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider to undertake certain activities and audits and to report to us on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure risks were assessed, plans were implemented to reduce risks to people and had failed to take all reasonably practicable action to mitigate risks to people from weight loss was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider to undertake certain activities and audits and to report to us on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had failed to operate effective procedures to safeguard people from abuse and harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider to undertake certain activities and audits and to report to us on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to operate effective systems and processes to ensure the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider to undertake certain activities and audits and to report to us on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person had failed to operate recruitment procedure that ensured an effective assessment of a person's character. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider to undertake certain activities and audits and to report to us on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to ensure staff received appropriate training and assessment to ensure they were competent to deliver their role and meet people's needs. This was a breach of

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

The enforcement action we took:

We imposed conditions on the provider to undertake certain activities and audits and to report to us on a monthly basis.