Coppermill Care Limited

Coppermill Care Centre

Inspection report

10 Canal Way
Harefield
Uxbridge
Middlesex
UB9 6TG

Tel: 01895820130

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Coppermill Care Centre is a residential care home providing personal care for up to 52 people aged 65 and over. At the time of the inspection 49 people were living at the service. The home has three floors, with the first-floor accommodating people living with dementia.

People's experience of using this service and what we found
The service was not always managed in a safe way. People were at risk of harm as some staff had not completed adequate training including fire training which meant they did not know how to support people in the event of a fire. People's medicines were not administered or managed correctly. Some risks to people had not been identified or addressed.

The provider carried out pre-admission assessments, but they were not comprehensive and lacked important information on people's physical and social needs, therefore the provider did not have all the necessary information to make informed decisions about people's admissions to the home.

The provider failed to ensure people's nutritional needs were always been met. People were not always offered healthy snacks, but the home did provide people with nutritional and well-balanced meals. Staff did not consistently support people to have choice and control at meal times. People were not always supported to eat in a caring or considerate way.

Some people's care plans were inaccurate and lacked information about people's needs, medical conditions and other information which meant staff were not provided with clear guidance to help care for people.

Staff recruitment was not always safe. Staff training had not always been completed. The provider failed to evidence how staffing numbers were decided as the service was not completing dependency assessments to determine staffing levels to ensure there was enough staff to meet the needs of the people.
People and their relatives told us staff were kind although our findings did not suggest a consistently caring service or a service that was always respectful of people and their needs.

People's end of life wishes were not always documented appropriately. This meant in event of a death staff, would not always be aware of people's preferences. The provider did not have effective processes in place to handle complaints.

Many of the people living at the home were living with dementia but the environment was not dementia friendly which meant the environment was not always meeting the needs of the people living there. People, did not always receive respectful or dignified care. There was a lack of person-centred practices to ensure people's needs were met. People's care records did not have up to date information to guide them about how best to support people.

Staff had not received up to date training which meant they did not always have the appropriate knowledge and skills to meet people's needs.

Quality assurance processes were ineffective. There were no effective auditing systems in place since the manager left and the nominated individual did not always have good oversight of the day to day running of the service. There was a risk people might receive inappropriate care.

We observed some occasions when people were not cared for in a dignified way. People and their relatives told us staff were kind although our findings did not suggest a consistently caring service or a service that was always respectful of people and their needs. However, we observed some positive interactions between staff and people during the daily activity sessions.

The nominated individual was not able to provide evidence of safeguarding incidents having been fully documented. We recommended the provider seek and implement national guidance in relation to safeguarding adults and record information accurately. People had access to external health care professionals when they were unwell.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 (report published 29 June 2017)

Why we inspected
This was a planned inspection based on the date of registration.

Enforcement
We have identified breaches of regulations in relation to person centred care, safe care and treatment, staff recruitment, staff support, dignity and respect, meeting people's nutritional needs, complaints and good governance. 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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 of 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 responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Coppermill Care Centre

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 was completed by two inspectors, an inspection manager, a member of the CQC medicines team 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
Coppermill Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection took place over three days and was unannounced on the first day. We announced our inspection on the second and third day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We reviewed information including notifications we had received about the service since the last inspection. Notifications are about incidents and events the provider must tell us by law, such as abuse.
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 nine people who used the service and six relatives about their experience of the care provided. We spoke with nine members of staff including a consultant who was providing two days of support a week, the deputy manager, the nominated individual, two senior care workers and five care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We carried out observations of care and support. Our observations included the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. These included 12 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. We contacted five social care professionals who regularly visit the service for feedback about the service and we received feedback from one professional.

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.

Using medicines safely

●Medicines were not administered safely as staff were not following the provider's policy and we found systems to record and investigate medicines were not always robust.

● We found staff had handwritten instructions onto one medicine administration record (MAR) which were not consistent with the prescriber's instructions to administer the medicines. Therefore, we could not be assured MAR charts were correct and this placed people at risk of not receiving their medicines as prescribed.

● People who needed topical creams to maintain their skin condition had not consistently been supported with the application of these creams. We reviewed two people's topical Medicine Administration Records and we found they were not receiving their medicines as prescribed. For example, one person was prescribed a cream to be applied twice daily, but it had only been recorded that they had been receiving the medicine once a day. This meant we could not be assured staff had applied the cream as prescribed to lower the risks of a deterioration in their skin condition.

● Staff who were administering medicines patches did not always know about the side effects of the medicines they were administering. One person was using medicines patches and the manufacturer's leaflet clearly stated patches must not be applied again to the same site for 14 days as it can cause irritation. Staff were not recording where they had applied the patch and when we spoke with these staff they were not aware of the side effects of this medicine. We raised this with the deputy manager and they told us they would ensure all senior care workers were aware of the possible side effects of the medicine.

● People had been prescribed medicines to be administered as required (PRN). We saw not everyone who had PRN medicines had a protocol in place to provide guidance for staff as to when they should be administered. When PRN medicines were given there was not a clear record made of the reason for use and the effect that the medicines had on the person. This meant the provider was not always following their policy as they did not have adequate information to evaluate the effectiveness of the medicines.

Systems were either not in place or robust enough to ensure the safe management of medicines. This placed people at risk of harm. This was a breach
of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback to the nominated individual they agreed to address the concerns we identified, and they told us they would arrange medicine training for all care workers and senior staff. We saw evidence of the confirmation booking for this training.

Assessing risk, safety monitoring and management

● Risks to people had not always been considered, assessed or planned for to ensure they received care safely. Where risk assessments were in place, they did not always contain accurate or up to date information. For example, one person was discharged from hospital with conditions affecting their legs, which required staff to have knowledge of the potential risks and to monitor for signs of deterioration. However, the person's risk assessment made no reference to these health conditions, so staff had the information to appropriately mitigate the risks associated with these conditions.
● In other people's files we found information was conflicting or incomplete and placed people at risk of harm as staff might not have the necessary information to mitigate risks in a consistent way. For example, in one person's choking risk assessment, it was recorded their overall risk was low but under the potential risk they were recorded as being at a high risk of choking.
● The provider did not always have effective arrangements to help protect people from risks associated with the environment. Staff were carrying out fire checks but when we spoke to the deputy manager they confirmed staff were not trained appropriately on how to use evacuation chairs in the event of a fire.

This placed people at risk of harm. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback to the nominated individual, they agreed to address the concerns we found.

Staffing and recruitment
● The provider did not always follow safe recruitment procedures before employing staff. The records of staff members' employment history were incomplete. The provider had not obtained a satisfactory written explanation of any gaps in employment. In some staff members' files we could see gaps had been highlighted by management, but we could see no evidence of what action was taken to address these matters and associated risks.
● One-person's employment history was incorrect as it included the date they were born. This anomaly had not been identified and addressed. We discussed this with the nominated individual and they recognised this was inaccurate and they told us they would revisit their recruitment practice.
● The provider had not always sought suitable references regarding the staff they employed. In some staff files the references titled 'to whom it may concern' but we could see no other checks had been completed in relation to their authenticity. In one staff member's file we checked the references and they didn't match the contact details listed in the staff member's application forms. The provider had not verified this and could not offer an explanation. In another staff file we saw one family member had completed a reference for one care workers. After the inspection the provider told us they had stopped accepting these types of references.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff recruitment procedures were effectively managed. This placed people at risk of harm. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not have a suitable system for assessing staffing levels in the home. This meant the home did not have an effective system for ensuring there were enough care workers available to provide direct care to people in a timely way. We reviewed the rota and we found some senior staff were not finishing their shift on time as there was not always enough senior staff available to cover the next shift. We spoke with the deputy manager about this and they confirmed this. They also told us "There is no process in place for assessing staffing levels."
● During the inspection we received feedback from people and relatives regarding the staffing levels at the

home. People we spoke with said they felt there were enough care workers but at times we saw people had to wait over twenty minutes to be supported to eat. We also observed care workers were not always present in the second-floor lounge where people were sitting. On the last day of our inspection we found there were no staff on the second floor for ten minutes. After the inspection the provider told us that people on the second floor could summon for assistance and would be able to call for help if they needed it.

● On the last day of the inspection the deputy manager found the dependency level and they told us they would be using this tool going forward.

Systems and processes to safeguard people from the risk of abuse

● The provider had a safeguarding policy in place, however we were unable to see if the provider had investigated and responded to two concerns in line with their policy. We discussed this with the nominated individual and they told us they were unable to locate all the information as the registered manager had left. As a result, the provider had started to investigate both cases again and we saw evidence of their investigation process.

● Some care workers had not completed their safeguarding training however the consultant assured all staff would be booked on training as a matter of urgency. Staff were aware of the procedures in identifying, responding to and reporting suspected abuse.

We recommend the provider seek and implement national guidance in relation to safeguarding adults from the risk of abuse to ensure they had robust systems in place to report and manage safeguarding concerns appropriately.

● People, relatives, and care workers thought the service was safe. One person told us, "I feel safe this is my home."

Preventing and controlling infection

● People were not always protected from the risk of infection and cross contamination. We noted there were areas of malodour on the first floor. We spoke with the nominated individual about this and they provided us with evidence of how they were trying to address this issue.

● Before meal times we observed people were not offered the opportunity to wash their hands and some people ate their food with their hands. Care workers wore aprons when serving food and supporting people in the dining room.

● The provider had been completing monthly infection control audits, but these had stopped once the registered manager had left. However, the home was clean and tidy in many places and people's rooms were mostly cleaned in line with their cleaning schedule.

Learning lessons when things go wrong

● The provider had systems to log incidents and accidents as they occurred in the service. From January to August 2019 there was a clear audit trail of accidents and incidents. We could see analysis of themes and trends in relation to the incidents that occurred. However, there was no information from September onwards. We spoke to the consultant about this and they showed us evidence of an action plan being implemented to address this.

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.

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

- People's dietary needs and nutritional requirements were not always assessed and accurately recorded to help people maintain a balanced diet. For example, staff failed to understand the Malnutrition Screening Tool (MUST tool), which is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese.
- We looked at one-person's dietary needs care plan which stated their risk was moderate however their MUST screening score placed the person at high risk. We spoke to senior staff about this and they could not demonstrate they were following the agreed care plan for someone who was at risk.
- Four people's Body Mass Index (BMI) was less than 20 and one-person's BMI was 13.04. If a person's BMI is less than 18.5 they are classed as underweight. We spoke to the deputy manager about this and they showed us evidence of people been referred to the dietitian however, it was unclear if care workers were following the advice of the dietician. We saw no evidence of care plans having been updated with guidance from the dietitian or good practice guidance for supporting people who were underweight.
- Throughout the inspection we observed people were regularly offered drinks such as tea or flavoured drinks and biscuits. At times people were offered snacks before their meals which meant at main mealtimes people were not always hungry and therefore we could not be assured people were eating healthily.
- We observed the lunch time meal and found there was ineffective arrangements in place to enhance people's enjoyment of their meals. There were no menus on the dining room tables and no condiments. The food was served on cold plates but kept warm in trolleys. We observed one person asking for their food to be reheated, but care workers did not reheat the food.

The provider had not ensured people's nutritional needs were being met adequately. This was a breach of Regulation 14 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

- The service was not always delivering care in line with current guidance and law. People's protected characteristics under the Equality Act (2010), such as religion and disability were not considered as part of the pre-admission process and we could see no evidence if these were discussed with people after admission or during their stay. This demonstrated that people's diversity was not always included in the assessment process.
- Pre-admission assessments had been carried out, however we found areas of the pre-admission assessments had not always been completed. This meant important information may have been missed relating to people's health and social care needs.

● Pre-admission assessments were sometimes done in person or over the phone. The deputy manager told us this initial assessment was used to start to formulate the care plan. However, we found gaps in the paperwork which meant the home did not always have up to date and accurate information. One person was recorded as "Suffers from schizophrenia" however their medical history provided by hospital discharge and GP showed no record of this condition ever been diagnosed.

The above meant that people's needs were not always appropriately assessed prior to moving into the home to make sure the provider would be able to meet their needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We raised this with the provider and they told us they would revisit how assessments were completed and would make the necessary improvements.
● Since the inspection the provider has arranged for all care workers and staff to receive training on assessments and care planning.

Staff support: induction, training, skills and experience
● The provider did not always ensure staff had the suitable skills for their role. The deputy manager told us care workers completed an induction and shadowed an experienced care worker. However, there were no records to show this had happened. Therefore, there was a risk thorough induction had not always taken place. Whilst medicine competencies had been checked there were no other records to show staff competencies in other areas had been adequately assessed during or at the end of this induction. This meant we could not be sure staff had the appropriate knowledge and skills to care for people.
● We could see some staff had been promoted from cleaners to care workers and from care workers to senior care workers. However, there were no records to show interviews, competency checks or further training had been carried out to support this transition. We spoke to the deputy manager about this and they told us they "simply didn't have the information. " This told us the provider had not ensured staff were adequately supported with relevant necessary training to develop the required skill sets to carry out a care worker's role
● The deputy manager told us all care workers had completed the care certificate. The Care Certificate is a nationally recognised set of standards that gives staff new to care an introduction to their roles and responsibilities. We looked at nine members of staff's paperwork for the care certificate and we noted that the writing style was very similar and, in some staff, files their workbooks were identical. We asked two care workers if they had completed the care certificate and they told us they hadn't however they had certificates stored on their file. This indicated the workbooks and training had not been completed by individual staff. The nominated individual recognised this when we discussed it with them.
● The provider did not have an overview of the training staff had completed and whilst there was a training record it was not up to date. The provider did not have a system to monitor and identify the training staff had completed.

The provider had failed to ensure staff received appropriate support, training, and professional development, to enable them to carry out the duties they are employed to perform.
This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

●The nominated individual agreed there were significant gaps in staff training records and told us they would be auditing all training and ensure deficits were addressed.
● Care workers completed a supervision meeting with their manager every three months and an annual appraisal. We saw records to demonstrate this happened and care workers confirmed they received regular

supervision.
Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● People's health needs were not always clearly recorded in their support plans. This meant it was sometimes hard to determine what diagnoses people had and what specific support they required. We spoke to the nominated individual about this, they told us they were migrating from paper support files to online and this was a reason for the confusion as some care workers were not confident using the new IT system.
● People had their oral health and mouth care assessments completed, although these were not always detailed. For example, they did not always include when people had last seen their dentist. In one person's file we read the person needed support with oral care, but this was not recorded within their support plan. We discussed this with the provider and they told us they would update all records.
● People were supported to access healthcare to help them live healthier lives. People confirmed the GP and chiropodist visited regularly. We also saw records as part of the care plan which showed these visits occurred.

Adapting service, design, decoration to meet people's needs
●The design and decoration of the premises did not always meet people's needs. On the first floor all of the people were living with dementia however, the environment did not always support these people to be as independent as possible. There were poor signage and points of reference throughout the building and the layout of the communal area was hard to navigate. The walls were painted in plain colours and there were very few photographs or pictures around the building to provide a homely feel.
The communal rooms had no homely features and people spent a long time in these areas. In one lounge there was a row of chairs facing each other. There were no crafts, books or games for people to enjoy.
●There was a malodour on first floor which made the area uncomfortable for other people who were sitting there and visitors to the home. We discussed this with the nominated individual and they told us how they were trying to address this issue. In other areas of the home we found the home was clean and maintained to a satisfactory level.

● Before the inspection the provider had contacted the CQC to inform us of their intention to update the general environment to ensure it was dementia friendly. During our inspection we saw work had started on some of the floors. Some of the bathrooms had been modernised. The provider had also recruited a dementia specialist to support them in this area of work. We will monitor progress in this area when we next inspect the service.
● Some people's rooms had been redecorated and felt homely. One relative told us, "We brought some of [person's] pictures in and then we went to the local shops to get something. By the time we got back the pictures were up on the wall – we were told how important it was to let [person] know it was their bedroom and to make it more familiar for them."

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.

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.

● DoLS applications had been made appropriately. We noted in some applications the local authority had recorded the home had a registered nurse based at the service. We raised this with the deputy manager and they concluded it was an error on the part of the local authority. However, they had not previously identified this themselves or raised it with the local authority to ensure correct documentation was in place.
● Not all staff had received training on the MCA but the consultant confirmed training would be provided.
● Senior staff we spoke with demonstrated a good understanding of the principles of the MCA. One person told us " I ask for people's consent before I support them."
● The deputy manager kept a record of all the DoLS authorisations, when these were authorised and due dates for renewal were recorded. We saw evidence these were in date.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- People were not always treated with kindness and compassion by staff as their approach when caring for people was often task focused and not person centred. There was a significant communication issue because some staff understood and spoke very little English and could not always engage with people and maintain an appropriate conversation.
- During our inspection we observed people trying to talk to staff and other staff telling people to come away as the staff were busy. One person responded by saying "I just wanted to say hello". The staff ignored this.
- We observed one person telling a member of staff how they felt unwell and the staff responded by asking the person to stand up.
- We could see no evidence of people consenting to care from male carers. We spoke with the consultant about this and they could find no evidence of people consenting to this. Male staff told us they sometimes provided intimate personal care to females.
- People who needed support to eat were supported first but during this time we saw there was limited interaction and meaningful conversation between people and care workers. People's choices in relation to their meals were not ascertained as they were not always asked what they would like to eat. Some people were eating from other people's plates and at no time did care workers intervene to try and rectify this situation.

The provider had not ensured that people were always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We spoke to the nominated individual about this and they recognised not being able to speak English was a barrier for staff. As a result, the home had taken action to improve communication by arranging for staff to have English lessons.

- Notwithstanding our observations, people and their relatives spoke well about some staff. One relative told us how "The activities worker had come in to see [their relative] on their day off." Friends and relatives told us they were made to feel welcome at the home and care staff always made them tea.
- People spoke fondly about some staff and people told us they enjoyed living at the home. One person told us, " I would give this place nine out of 10 and that's only because I am not in my own home."
- Another person told us about the laundry staff taking the time to mend their cardigan which was

important to them as it was their favourite item of clothing.

Respecting and promoting people's privacy, dignity and independence

● In the dining room there was a list of people's names together with their hydration and nutritional needs, which was displayed on the wall. This information was personal to people and the confidential nature of this information was not maintained as others could read the information. This told us staff were not always understanding the importance of ensuring people's dignity and privacy was respected. We spoke to the deputy manager and they removed the form from the wall.

● During our inspection we observed staff knocking on people's doors and waiting before entering.

● People told us how they were encouraged to stay independent, one person told us, "I pick my own clothes and nail polish and staff help me but only if I need it." During our inspection we observed the activities co-coordinators promoting people's independence by offering people choice in how they wished to spend their day.

● One person told us how care workers supported them by respecting their wishes regarding where they ate their meals.

Inadequate

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 inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- At the last inspection we made a recommendation for care plans to be written in a more person-centred way, whilst some improvements had been made to the language used in care plans were often inaccurate and lacked important information on people's support needs. We read in one person's file, they had" high cholesterol". We checked this person's dietary needs care plan and there was no mention of the person having high cholesterol and a low fat diet. This told us important information was not recorded or planned for correctly.
- Some care plans included conflicting information about people's healthcare needs. Care plans referred to different healthcare conditions, but there was no information about these and no guidance from relevant healthcare professionals. We reviewed two people's behavioural needs assessments and we found the care plans did not always effectively identify or contained guidance on how to meet the person's needs.
- Reviews of people's care had not always been completed when people's needs changed, and we could not always find evidence of people being involved in their reviews, where these were completed. We could see evidence of people's physical health needs deteriorating however the support plans had not been reviewed and updated to reflect people's changing health care needs.
- In another person's personal care plan it was recorded they needed a bath but when we checked the daily notes this person was mainly being provided with a strip wash.

The lack of person-centred care plans placed people at an increased risk of not having their needs met. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

- People had communication plans completed as part of their care plans, however at times we saw staff did not always ensure people's communication needs were being addressed. For example, we read one person required pictures to communicate but during our inspection we did not observe this person being shown pictures to help them communicate.
- We observed care workers repeating the same questions and not listening to people's answers as they clearly did not react to their responses. This was because some care workers had limited understanding of

English. Other times people were trying to engage with staff and the staff simply didn't understand the questions.

This placed people at an increased risk of not having their needs are met. This was a further breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● People had end of life plans in place, which contained people's advance wishes at this time of their lives. However, the information was not always correct and sometimes lacked detail. In one person's death and dying care plan their recorded name was wrong. Therefore, this plan may have related to a different person who had different needs.

● Recently one person had died at the home and we spoke to their relative, the relative told us the home had provided them with the wrong paperwork which was misleading and made planning the funeral difficult. We reviewed the paperwork which people received, and we saw it was confusing. We raised this straight away with the consultant who assured us they would update the paperwork. We will check this when we next inspect.

The above placed people at an increased risk of not having their needs are met. This was a further 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

● The provider did not have robust arrangements to ensure that complaints were appropriately investigated, responded to and resolved. The provider did not also demonstrate lessons were learnt when complaints were substantiated to help prevent reoccurrence.

●We saw there have been six complaints up to August 2019. We asked the nominated individual if there have been other complaints after August, but they could not tell us if there had been any and these were not recorded. We found that not all the complaints were acknowledged within the timescale specified in the provider's complaints procedure

● Of the seven complaints, we saw a response with an action plan for two of the complaints. We also saw a record where one complainant wrote to the registered manager at the time, to ask why they had not heard from a previous complaint they had made. This was because not all complaints were acknowledged or recorded as complaints.

The fact that complaints were not responded to appropriately by the provider was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● In some people's life history and social record there was no information on what was important for people, we spoke to the deputy manager and they told us this information would be uploaded to the new support planning system.

● The home had a communal area known as the ''hideaway'' which was a restaurant and bar. During our inspection we spoke with staff who all agreed it was not used enough. Staff recognised they should be doing more with the space as it was only used three times a week for activities. The space was sometimes used for families to have meals together, including being booked for families to have Christmas dinner together.

● On the first day of the inspection there was a craft activity for people to participate in on the ground floor

and we observed a small group of people enjoying this activity, however this was the only activity offered. Over the course of our inspection we saw no specific activities for people who were living with advanced dementia. We discussed this with the provider and they assured us this was an area they would be exploring with the dementia specialist.

● Some people told us they had access to activities internally and externally to the home. People told us there were some activities provided at the service which they enjoyed. One person said, "I enjoy dominoes." Another person said, "I like the activities workers they put lots of events on."

● During our inspection we observed the activity co-ordinators speaking with people and planning a schedule of events for the Christmas period.

● People who did not have relatives nearby were supported by a local befriending service which visited the home regularly.

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; Continuous learning and improving 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; Working in partnership with others

- The provider did not have appropriate oversight of the home. There was a significant lack of oversight and monitoring of the service and as a result they had not identified risks relating to managing medicines, meeting people's nutritional needs, caring for people, dealing with complaints, recruitment of staff and a lack of understanding of delivering person centred care.
- In the absence of a registered manager, the deputy manager was left in charge of the home on a day to day basis. However, they lacked an understanding of the necessary audits and checks to be carried out to ensure people were not placed at risk of poor and inappropriate care and to monitor the service provision. Therefore, safety issues had been left unnoticed. For example, there were no audits relating to infection control or staffing since the registered manager left in October. There was also no consistent monitoring of the care people were receiving and the way staff engaged and interacted with people. Adequate records were also not maintained of staff training to ensure they had or continued to have the required skills to provide people with effective care and support.
- The provider was transitioning all of their care records to an on-line system and this had resulted in the quality of care planning to vary depending on the skills and knowledge of the staff responsible for updating the records. Care plans were not accurate and, in some cases, recorded the wrong diagnosis, name or needs. They were not audited to check if they were accurate and contained all relevant and important information about the person and as a result there were risks people might receive unsafe care.
- Furthermore, there was a lack of records in relation to the management of safeguarding incidents and dealing with complaints.
- The service was without a registered manager for a period of time before the inspection and this had significantly impacted on the home. As a result the provider did have not effective oversight of the day to day running of the home. For example, the provider was unable to access some of the records stored by the previous manager which meant they did not have access to important information which affected the day to day running of the home.
- The provider's systems and arrangements did not always ensure people received care which was person-centred. Staff did not communicate with them well and often did not understand or respond to what people were saying. Care plans were inaccurate, and staff did not always follow guidance within care plans to meet people's needs . The provider had not ensured these practices were identified and addressed promptly to

prevent reoccurrence.

The above shows that systems were either not in place or robust enough to demonstrate the quality and safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Before the inspection the provider had recruited an experienced consultant for two days a week to help with identifying shortfalls with the quality of the service, so these could be addressed. The consultant had developed an action plan which had actions for completion against many of the issues we found during our inspection.
● Notwithstanding the above records showed that meetings for people living at the service were facilitated, and the provider was trying to address the concerns people raised during these.
● Staff told us they attended meetings with management to discuss the service and raise any issues. We saw evidence of team meetings being held and actions having been taken to address issues when these were raised.
● We received feedback from one healthcare professional who said, "Found the home to be well run and the staff conscientious, caring, kind and considerate and very helpful. Any concerns are always acted upon quickly. The staff have a genuine affection for the residents and their care which is reassuring to see. "
● Management and staff were working in partnership with a range of professionals such as the district nurses and chiropodist.

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
● As part of the inspection we spoke with the nominated individual about their understanding of their responsibilities under the duty of candour and they demonstrated they understood their responsibilities however they recognised they did not have appropriate oversight of the service since the manager left as they had failed to follow up on some of the issues we found during our inspection.
●During our inspection when we raised concerns with the nominated individual they showed evidence of the actions they were taking to address some of the concerns we had identified. For example, the nominated individual had sourced medicine training for staff, recruited a dementia specialist, arranged for a nurse from the providers other home to attend and support staff in medicines and care planning.
The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure people where treated with dignity and respect. Regulation (10)(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not always ensure service users' nutritional needs were being met. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not demonstrate that the service was responding to complaints according to their complaints process and to the satisfaction of complainants Regulation 16

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure service users received care which met their needs and preferences. Regulation 9(1)

The enforcement action we took:

We have served a Warning Notice on the provider for failure to meet this Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always ensure safe care and treatment because they had not always assessed risks to service users safety nor had they done all that was reasonably practicable to mitigate the risks to the safety of service users. The provider did not always ensure the proper and safe management of medicines . Regulation 12(1)

The enforcement action we took:

We have served a Warning Notice on the provider for failure to meet this Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not always operating effective systems and processes to assess, monitor and improve the quality and safety of the service and to assess, monitor and mitigate risks. The provider failed to maintain an accurate, complete and contemporaneous record in relation to the care and treatment provided.

	Regulation 17(1)

The enforcement action we took:

We have served a warning Notice on the provider for failing to meet this Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person was not always operating effective systems to ensure the safe recruitment of staff. Regulation 19 (1)

The enforcement action we took:

We have served a warning Notice on the provider for failing to meet this Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure service users were cared for by staff who were suitably trained or supervised to carry out their role. Regulation 18 (2)

The enforcement action we took:

We have served a warning Notice on the provider for failing to meet this Regulation