Esteem Care Ltd

Banksfield Nursing Home

Inspection report

20 Banksfield Avenue
Fulwood
Preston
Lancashire
PR2 3RN

Tel: 01772733001
Website: www.banksfieldnursing.co.uk

Date of inspection visit:
31 August 2021
08 September 2021
28 September 2021

Date of publication:
05 December 2022

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
Banksfield Nursing Home is a care home providing personal and nursing care to 31 people aged 65 and over at the time of the inspection. The service can support up to 42 people. The service consisted of a 20-bedded unit on the ground floor, providing general nursing care. On the first floor, nursing care is provided to a maximum of 22 people who live with dementia.

People's experience of using this service and what we found
The provider failed to ensure people were consistently protected from the risk of avoidable harm. For example, the risk of choking, aspirating, malnutrition, dehydration, skin break down and clinical health deterioration. During the inspection the provider took steps to mitigate the risk people had been exposed to and assured us lessons would be learnt.

The provider failed to ensure safeguarding incidents were consistently identified or acted on. Recommendations made by the Local Safeguarding Authority were not always followed and lessons were not always learnt. Not all staff had received training in safeguarding adults. People's representatives told us they were not always confident people were safeguarded because of incidents that has occurred including service user altercations and choking. During the inspection the provider took steps to improve staff responsiveness to safeguarding incidents and we received assurances that all incidents of risk and actual harm had been reported to the local safeguarding authority for their investigation.

People were not always supported to have maximum choice and control of their lives and staff did not consistently support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support best practice around use of the Mental Capacity Act (MCA), Best Interest Assessment (BIA) or Deprivation of Liberty Safeguards (DoLS).

Cleanliness throughout the dementia care unit on the first day of the inspection was poor. On the second and third day of the inspection we noted improvement however, the environment in some areas of the service remained worn and difficult to effectively clean.

Infection Prevention and Control (IPC) processes were not consistently effective. We asked the local IPC team to support the provider to improve their systems and processes to ensure people were effectively protected from the risk of COVID-19 and other infectious disease. The provider assured us they audited and actioned IPC shortfalls during the inspection and engaged with supporting external IPC professionals.

Relatives and staff complained to us about a lack of staff on duty. During the inspection staffing levels were increased. There was a dependency tool relied on to calculate numbers of staff required however, due to the high level of new and or agency staff deployed we found staffing levels at the start of the inspection did not ensure people's needs were met in a timely or person-centred way.

Staff did not always ensure people's medicines were managed in a safe and effective way. For example, we found failures in relation to the use of thickening agents to prevent people from choking and aspirating, application and recording of topical medicines, the availability of prescribed medicines and staff training.

There was a system in place to identify accidents and incidents however, the management of incidents and lessons learnt were not always recorded.

The provider did not always ensure people's needs were assessed, evaluated or reviewed in a person-centred way. For example, a new service user was admitted their needs and preferences had not been assessed despite them displaying distressed reactions and changes in their physical health.

The provider failed to ensure all staff were suitably trained to undertake their roles and responsibilities. During the inspection we received assurances from the provider that training courses were scheduled.

We found the environment was not effective for people who lived with dementia. The service lacked soft furnishings and access to dementia friendly stimulus.

On the first day of inspection we observed staff failed to effectively acknowledge people's non-verbal requests for support on the dementia care unit. On the second and third day of the inspection we noted improvement in staff presence in communal areas, staff were more attentive and recognised when people tried to communicate with them.

People did not have regular access to stimulating and meaningful activities.

Quality assurances processes were in place however did not identify some of the failures found at the inspection including; staff training, medicines management and environment. During the inspection a new manager and regional manager commenced in post and both demonstrated commitment to improvement. We were reassured by the regional managers risk mitigation and transparency throughout the inspection process.

Staff told us they felt the service had stabilised in the last few weeks since the previous manager had exited the business. Staff told us they felt able to raise ideas and involved in the running of the service.

People and their relatives told us they felt confident to raise their concerns/complaints some feedback identified relatives felt frustrated about delayed action being taken when they raised concerns.

We observed staff consider people's dignity and respected their privacy. Staff discussed and assessed people's end of life needs and preferences with them or their representatives when they were near to end of life.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 March 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

The inspection was prompted in part due to concerns received about safeguarding people from the risk of avoidable harm, management of the service, staffing levels and culture. A decision was made for us to inspect and examine those risks.

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

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

We have identified breaches in relation to person-centred care, consent to care and treatment, keeping people safe, protected from avoidable harm, abuse and neglect, nutrition and hydration, governance and delegation of sufficient numbers of experienced, suitably trained staff at this inspection.

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 further 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 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**

Banksfield 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.

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

Inspection team
The inspection was carried out by four inspectors who undertook site visits, one inspectors who undertook remote calls to staff and an Expert by Experience who contacted people's relatives by telephone, 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
Banksfield Nursing Home 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 did not have 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.

The service had a nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
All three days of inspection site visits were unannounced.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service and seven relatives about their experience of the care provided. We spoke with fifteen members of staff including the operations manager, regional manager, manager, deputy manager, two registered nurses, care workers and the chef. We used 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. This included two people's care records and multiple medication records. We looked at two 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, actions plans and quality assurance records. We spoke with four professionals involved in risk mitigation strategy meetings to support the provider to make immediate improvements.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong
At our last inspection the provider had failed to demonstrate safety had been managed and medicines were not effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● The provider exposed people to risk of avoidable harm; there was a failure to continuously risk assess or carry out risk assessment strategies. For example, we could not be sure people prescribed thickening agents to prevent them from aspirating on fluids received their prescribed treatment. Staff did not always know the needs of people they supported and therefore did not always sufficiently protect them from harm. One person choked and needed emergency first aid because staff gave them unsafe foods, staff exposed this person to the risk of choking on multiple occasions.
● Deterioration in people's physical health was not acted on in a timely way. We found examples were people needed medical treatment because staff failed to monitor their diet and fluid intake and physical health observations and prevent their health deteriorating.
● Staff did not receive sufficient support or training about people's individual needs and preferences. One person was continually given a food which their care plans and risk assessments clearly outlined they should not and did not want to eat.
● Accident and incident reporting appeared low. Incidents reported were not always effectively reviewed or acted on.
● Two people were involved in an unwitnessed incident which resulted in physical harm, a basic account of the incident had been recorded however the record had not been reviewed by a manager in line with the providers incident policy. Protection plans had not been completed for the person who sustained injuries to prevent further incidents occurring.
● We found two people who lived with dementia had expired foods in their personal bedroom fridge. This placed them at significant risk of avoidable harm because they were unable to identify that the food had expired and was fermented.
● People did not always receive their medicines in a safe and effective way. Failures included; fridge items were not stored at a safe temperature, information about how to identify when people needed their 'when required' medicines was insufficient; the service was often reliant on bank and agency staff to administer people's medicines, this meant they would not know how to identify when someone who was unable to

reliably communicate they were in pain, distressed or constipated.
● Environment safety including fire safety checks were not always carried out in line with the related policy and procedures. The environment was not well maintained for example, the sluice door lock was faulted and staff told us this had been an issue for many months and bath sides on the dementia care unit were broken, again this had been ongoing for some time.

We found systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all failures identified were included in a service improvement plan with high risk actions prioritised for completion.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to demonstrate people were consistently protected from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Safeguarding incidents were not always identified or acted on. Recommendations made by the Local Safeguarding Authority were not always followed and lessons were not always learnt. For example, one person's conditions of their DoLS were not consistently followed or known by staff delegated to support them.
● Care records continued to incorporate the use of restrictive practices identified as 'safe holds', this meant staff were directed to physically restrain (hold) an individual during incidents of distressed behaviours. One person's care plan stated, 'For trained staff to utilise soft holds on [name] when [name] presents with behaviour that challenges'. The care plan and risk assessments did not reference positive behaviour support strategies, de-escalation or distraction techniques to utilise. Training records showed staff had not been trained in how to safely restrain or restrict a person's movements.
● We identified the security of people's personal belongings was not always safeguarded. One person had multiple personal items provided by their relative and these had been lost.

We found systems were not robust enough to demonstrate people were safeguarded from abuse or improper treatment. This placed people at risk of harm. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed care plan records were updated and any unsafe or improper guidance around the management of people's distressed reactions removed. The provider also assured us staff would receive immediate coaching and training had been scheduled for positive behaviour support planning.

Preventing and controlling infection
● Good hygiene and cleanliness standards were not maintained on the dementia care unit. Corridor walls and door handles were stained with faecal matter and dried food, some bedroom floorings were torn, and

items of furniture were worn which caused difficulty in effective sanitation of communal areas. The provider took immediate action and on the second and third days of the inspection we saw cleanliness standards had improved.
● The provider failed to carry out daily body temperature checks for people who lived at the service in line with their COVID-19 policy and procedure and national guidance for managing COVID-19 in care homes.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate infection prevention and controlled had been effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have signposted the provider to resources to develop their approach, the provider confirmed they undertook their own IPC audit and are being supported by the local authority IPC team.

● The provider had processes in place to screen visitors for COVID-19 before the entered which helped prevent the spread of infectious disease. We were assured the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
At our last inspection we recommended the provider reviewed the deployment of staff at busy times to ensure people's needs were met in a timely way. The provider had not made enough improvement.
● Staff and people's representatives consistently told us people had to wait for support because numbers of staff deployed were insufficient. Comments included; "I can be on the unit for 10 minutes and not see a member of staff, people are left unsupervised", "The staff always seem to be rushed. Not sure if they know [name's] needs as they don't really know the residents." And "Staffing was low on most of my shifts. I often worked with less staff than were needed to meet people's needs and look after them."
● People did not always receive personal care in a timely way.

The provider failed to consistently deploy suitable numbers of experienced and trained staff. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not always recruited in a safe way. We found shortfalls in record keeping for two staff recently recruited, employment references and criminal record checks were not always in line with the providers recruitment policy and procedure. Immediate action was taken to ensure all recruitment decisions were in line with the policy and procedure and staff deployed were of good character.

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 requires improvement. At this inspection this key question has 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
At our last three inspections the provider failed to ensure peoples' nutritional needs had been accurately assessed and people did not always receive a nutritious diet or sufficient levels of hydration. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 14.

● People continued to be at risk of malnutrition and dehydration because diet and fluid intake was not consistently monitored and nutritional risk assessments were not always carried out.
● Staff failed to accurately assess one person for the risk of malnutrition. The electronic care planning system stated a recorded height of 0.2m and therefore the pre-generated nutritional risk assessment was incorrectly scored, staff had not identified this error. The person had lost 1.4kg in 15 days and this had not been recognised or acted on. We found the person should have been discharged from hospital with supplements to prevent weight loss, staff had not identified this need or taken action to order a prescription.
● Another person had a long history of malnutrition risk and was under the care of dieticians. Their care records stated the person should be weighed weekly however they had not been weighed since July 2021.
● Multiple people had not received adequate levels of fluids to keep them sufficiently hydrated. For example, one person's fluids intake records showed they had only taken 20mls of fluids between midnight and 11.30am, we observed this person alone in their bedroom with two jugs of untouched fluids, staff told us at 11.30am they had not assisted the person with personal care or breakfast. The management team were immediately informed, and action was taken to ensure the person was correctly supported.
● We observed people who lived on the dementia nursing unit receive poor mealtime experiences. People were not sufficiently supported or prompted to eat and drink. People were also placed at risk of choking because staff did not always supervise them when sat near foods which they were unable to safely eat. Staff demonstrated little knowledge about people's dietary risk and nutritional needs.

Systems and management oversight were not robust enough to consistently ensure people's nutrition and hydration needs were met. This placed people at risk of harm. This was a breach of regulation 14 (Meeting Nutrition and hydration) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The senior management team took immediate actions to reduce the risk and increase staff knowledge

about people's needs. Our observations across day two and three of the inspection showed improvements had been made.

Staff support: induction, training, skills and experience
● Staff did not have the right skills and competencies to meet people's needs and safely support them. For example, only one staff member had been trained in basic life support, 30% of staff had not been trained in or received recent basic fire awareness,32% of staff had not undertaken or renewed safeguarding training and only one staff member had undertaken medicines training and been checked for competency.
● Staff supported people who displayed distressed reactions on a frequent basis. The provider failed to ensure staff were trained and supported to ensure effective and safe care was delivered. We found examples of staff undertaking restrictive practices without specific training to do so in a safe way.
● All of the staff we spoke with told us they had not received a supervision or appraisal in the last six months.

Systems were either not in place or robust enough to demonstrate sufficient training and support for staff. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed training had been scheduled.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's needs and choices were not effectively assessed.
● People experienced deterioration in their clinical health without sufficient assessment, observation or consideration from nursing staff deployed to care for them. One person was admitted to hospital with a urine infection, dehydration and concerns around their low body weight, we looked at fluid balance records which showed they were taking a low daily amount e.g. 225mls, 465mls and 50mls across a three-week period. Their care records did not show how they had been assessed, we could not be sure any clinical observations were taken or acted on until the day of admission to hospital.
● Another person had a skin condition that had not been adequately assessed, monitored or acted on.
● Three external health care professionals told us they felt frustrated because when they made recommendations about how to improve the support people received their advice was not always communicated to staff or acted on. People's care plans showed evidence of referral to external professionals however, this was not always in a timely way.

Systems were either not in place or robust enough to demonstrate safe care and treatment. 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.

The provider responded immediately during and after the inspection. They confirmed people would be reassessed and health needs carefully monitored with oversight of the new manager who was a registered nurse.

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.

● People were not always supported in line with principles of the MCA. We found examples of restrictive practices including restraint which had not been fully considered through capacity assessment, best interest decision making or liaison with specialist external health professionals.
● Conditions of a person's DoLS were not met. This placed other service users at risk of avoidable harm and an incident occurred which could have been prevented. Further to the incident the provider failed to fully consider the person's emotional needs in line with the MCA and DoLS and implemented restrictive practices, staff told us this had a detrimental effect on the person's wellbeing. We ensured the provider took steps to safeguard the person and other service users.

Systems were either not in place or robust enough to demonstrate compliance with principles of the MCA and associated DoLS. This placed people at risk of harm. This was a breach of regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all service users would be reassessed and where needed DoLS applications would be made.

Adapting service, design, decoration to meet people's needs
● The first-floor unit was not well designed to meet the needs of people who lived with dementia. There was a lack of soft furnishings and stimulus such as engaging objects to help people live meaningful lives. People congregated in the hallways, the dining area was not set, therefore did not encourage people to orientate to their surroundings at mealtimes. The provider told us about plans to change the environment to make it more dementia friendly.
● We asked relatives for feedback about the design and decoration at the service. Relatives told us; "It's not very welcoming, they've got a job lot of cheap paint, oh my god the choice of colours, pink and grey everywhere" and "On the whole it's ok, they are trying to improve the place and there is some decorating going on at the moment. The garden needs improving."

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 deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always supported to express their views or be involved in making decisions about their care. One person was deprived of their liberty and under close supervision, their experiences of this process was not fully considered or recorded. Another person was recently admitted to the service and the provider failed to engage with them or their representative about their preferred care or involve them in the decision-making process including use of sedative medicines.
- Staff did not always respect people's preferences because they were not always aware of them. For example, one person did not want to eat a certain food because of religious reasons. Not all staff were aware of this and therefore the person received the food, due to having cognitive impairment they accepted the foods provided and were not aware. Another person did not receive support as recommended by the community mental health team to ensure their emotional needs were met, staff did not always consider their equality or diversity.
- Care records provided no information about when they were last reviewed with people and or their representatives. We asked people's representatives if they had been invited to participate in the care planning process and reviews. They told us; "[Name] hasn't had his care plan reviewed in over 2 years. No updates about the care since Covid." "[Name] has been a resident since April 21. No, not up to now. Staff keep me informed about hospital appointments and ask if I want to attend."

People were not consistently supported in a person-centred way. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all service users would be reassessed in a person-centred way and supported where possible to be involved in the decision-making process.

Respecting and promoting people's privacy, dignity and independence

- We observed the support people who lived with dementia received from staff. Staff did not always recognise when people displayed emotional needs or attempted to communicate with them for example; whimpering, crying or seeking attachment by means of trying to reach out to touch objects or passers-by. Staff failed to identify because they were not sufficiently skilled or trained. On the third day of the inspection we saw improved interventions and staff told us they had been supported by the deputy manager to recognise when people were trying to communicate.

● People who lived on the nursing unit told us staff supported them in a kind and caring way. People's relatives provided mixed feedback about their experience of staff; "Yes, the staff are pleasant but so busy" and "The staff aren't too bad, they're all right, they care a bit."
● We observed staff consider people's dignity and respected their privacy.

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 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

- There was a fundamental failure by the provider to ensure people received personalised care. People were placed at risk of avoidable harm because they were not always accurately assessed, therefore their care was not always effectively planned.
- People's changing needs were not always responded to in a timely way. People's physical health had deteriorated because staff had not acted on their reduced diet and fluid intake or change in behaviours suggestive of infection. Staff exposed people to the risk of harm because they did not always know their personal needs and preferences. For example, a person was given unsafe foods which caused them to choke and need emergency first aid.
- Staff told us they felt unable to safely and effectively meet people's needs because they had not received sufficient training or support. Comments included; "The standard of care was poor. Many staff did not have the training they needed to do their jobs properly for instance they were not trained to deal properly with the challenges of people who suffered from dementia, whose behaviour was unpredictable, staff were not prepared for this" and "It is hard to know what people need because we don't get a good handover, we just get on at the start of shift and rely on the other person we are working with".

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

- The provider told us they were in the process of recruiting an activity co-ordinator. There had not been one deployed for several months due to staff sickness. Across both unit's people did not have regular access to meaningful activities.
- We observed a very task-led provision of care. Staff focused on supporting people with personal care and meal service. People could access communal areas to watch television. We did not observe any meaningful activities to help people feel stimulated or socially included.
- People or their representatives were asked about their pastimes, occupation and life story. This information had been recorded in people's care records however was not always understood by staff delegated to supported them.
- One person subscribed to a daily newspaper however, not all staff were aware of this and therefore the person rarely received their newspaper. This showed a lack of respect and consideration for their person-centred needs and preferences.

People were not consistently supported in a person-centred way. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all service users would be reassessed in a person-centred way and supported where possible to be involved in the decision-making process.

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.
● On admission staff assessed people's communication needs and preferences. Care records included information about people's preferred communication and prescribed aids including spectacles and hearing aids. The provider was heavily reliant on bank and agency staff and this meant support for people with communication needs was inconsistent.
● Over 30% of staff had not received dementia awareness training. During our observations we saw staff lacked skills to identify when people who lived with dementia tried to communicate. We received feedback from relatives and visitors about the amount of people who lived on the dementia unit that regularly shouted or screamed. We discussed this with the senior management team who acknowledged the immediate need for staff to be coached and developed to understand how to effectively support people with advanced dementia.

Improving care quality in response to complaints or concerns
● The provider listened to people's feedback and provided a response to their complaint or concerns in a timely way. People and their representatives told us they felt confident to raise any concerns and had access to the complaint's procedure.

End of life care and support
● Staff discussed people's end of life care needs and preferences with them or their representatives when their health deteriorated. Decisions were recorded in people's care records. The provider acknowledged the need to improve timescales for end of life discussions and for advanced care planning meetings to be held before people's health deteriorated to ensure were possible they could still be involved in the decision-making process.
● Staff had access to online training for end of life care awareness, 20% of staff had not completed or renewed this training. The provider did not ensure staff were trained in clinical skills including; syringe driver, death verification or advanced care planning.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider failed to assess and monitor the quality and safety of the service provided and to mitigate risks relating to the health, safety and welfare of people who lived at the home. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider has been in breach of regulations 12 (safe care and treatment), 14 (nutrition and hydration) and 17 (good governance) for four consecutive inspections.
● At this inspection we found the provider exposed people to serious risk of avoidable harm in relation to safe care and treatment including; choking, aspiration and deterioration in physical health due to lack of skilled nursing oversight as outlined in the safe domain of this report.
● People did not consistently receive person-centred care. We found examples were people had not achieved good outcomes because staff lacked the knowledge and skills to identify how to keep people safe. For example, the provider did not always ensure accidents and incidents were investigated and risks sufficiently mitigated to protect people from the risk of avoidable harm.

People were exposed to avoidable harm because the provider failed to effectively govern the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to submit statutory notifications after serious incidents had occurred as required by regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009. This meant that CQC could not undertake its regulatory function effectively. This will be dealt with outside of the inspection process.
● A new manager and regional manager commenced in post during the inspection, they both demonstrated clear understanding of the risks identified at the inspection and provided us with assurances of risk mitigation.

Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People were at serious risk of avoidable harm because the providers governance systems failed to identify, remedy or prevent incidents happening.

● There was a long-standing history of non-compliance with legal requirements, this showed the provider did not ensure continuous learning when things went wrong.

● During the inspection we were assured by the regional manager that transparency was maintained with people and their representatives when failings were identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider was supported by local authority and health commissioners during and after the inspection. Before the inspection we received feedback from visiting professionals who told us their support and recommendations were not always acted on or communicated throughout the staff team.

● We observed people who lived on the general nursing unit approach staff in charge to report concerns or ask questions. People told us they felt confident to approach senior management.

● People's representatives told us they felt confident to raise concerns however were not sure who the manager or responsible person was. Comments included; "I don't know who the manager is, who's in charge, I've never been introduced. I met someone from head office, he was involved and hands on and friendly" and "I'm not aware of who the current manager is, apparently the previous manager has left."

● We asked staff if they felt involved and able to report any concerns or ideas to the senior management team. Staff told us, "I feel confident taking any information of concern to the manager and I believe the manager would follow it up and report it to the correct authorities."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received person-centred care and treatment.

The enforcement action we took:

x

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to consistently ensure people received care and treatment in line with principles of the MCA and associated DoLS.

The enforcement action we took:

x

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to protect people from the risk of avoidable harm. The provider failed to ensure people consistently received safe care and treatment.

The enforcement action we took:

c

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to consistently safeguard people from abuse, avoidable harm and unfair treatment.

The enforcement action we took:

x

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure people's nutritional and hydration needs were effectively assessed and supported.

The enforcement action we took:

x

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective governance systems were in place and carried out.

The enforcement action we took:

x

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure effective staff training and supervision processes were in place.

The enforcement action we took:

x