# The Abbeyfield (Maidenhead) Society Limited

# Nicholas House

## Inspection report

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Date of inspection visit:
09 January 2020
10 January 2020
13 January 2020

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service:
Nicolas House is a residential care home that is registered to provide care for up to 30 people, this includes people living with dementia. Accommodation is situated on three floors with two lounges and a conservatory. There are specialist baths and wet rooms. The home also offers respite provision and day care facilities for non-residents. At the time of our inspection, 25 people were using the service.

People's experience of using this service and what we found;
During this inspection, we checked to see if the provider had addressed the concerns found at our previous visit on 12 February 2019. We found the provider had not made the improvements they told us they would, and there were multiple repeated breaches of the regulations.

People were placed at significant risk of harm. Risk management plans to reduce identified risk of harm to people's health and welfare, did not provide staff with enough information to reduce or mitigate those risks. Unsafe recruitment practices placed people at risk of being cared for by staff who were not suitable. The provider did not take prompt action to address poor staffing levels. People were placed at potential risk of harm as the service did not act on recommendations to prevent fire. The provider did carry out necessary checks to ensure staff were competent to administer medicines safely. We have made a recommendation about this.

The assessment of people's needs and choices and delivering of care was not in line with standards, guidance and the law. The provider could not be assured staffs' working practices would prevent discrimination and protect people's human rights. Staff were not appropriately inducted, trained and supported. The service did not always make effective use of health and social care professionals to support people to achieve good health outcomes. As a result of this we could not establish if people received effective oral hygiene care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests.

Peoples' care needs, and preferences were not always considered and regularly reviewed to make sure they were still relevant. The provider did not maintain a record of all complaints, outcomes and actions taken in response to complaints.

The management team lacked an understanding of equality, diversity and human rights. We have made a recommendation about this. There were no systems in place to communicate how feedback received had led to improvements. We have made a recommendation about this. There were ineffective quality assurance systems in place which did not improve the quality of the service and protect the welfare and safety of people.

People and relatives were happy with the service provided and spoke positively about the caring nature of staff. Staff said they were supported and described the management of the service as open and approachable.

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 6 March 2019) and there were 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 not, enough improvement had been made and the provider was still in breach of regulations.

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

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, need for consent, safe care and treatment, receiving and acting on complaints, good governance, staffing and fit and proper persons employed.

Please see the action we have told the provider to take at the end of this report.

We have issued the provider with a warning notice for staffing.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 their 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.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service caring?**

Good

The service was caring.

Details are in our caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

# Nicholas House

**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 carried out by an inspector and a specialist advisor, who provides support to people whose health prevents them doing the activities that matter to them. The specialist advisor was only present on day one of the inspection.

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

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

Notice of inspection
This was an unannounced inspection.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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-

Throughout the inspection we gave the provider and registered manager opportunities to tell us what improvements they had made since our last visit.

We used the Short Observational Framework for Inspection (SOFI) during lunch. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interactions between staff and people living in the home throughout the day, both whilst giving support and during general interactions.

We spoke with two people, five relatives, an activity co-ordinator, a physiotherapist, four care workers, the deputy manager, the registered manager and the general manager. We viewed 10 care plans, three staff files in relation to recruitment, induction and supervision records, training data, four medicine administration records, policies and procedures and a variety of records relating to the management of the service.

We requested additional evidence to be sent to us after our inspection. Information received was used as part of our inspection.

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 has deteriorated to inadequate. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment.

At our last inspection we found people were not always supported by staff who had been recruited safely. This was a breach of Regulation 19 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 19

● We looked at the recruitment records of three members of staff who had been employed by the service since our last visit in February 2019. Recruitment records still failed to follow the provider's own recruitment procedures. For instance, the recruitment policy stated, "Application forms must be completed… and…. references will only be taken up with permission of applicant but must include a reference from their current/last employer."
● We found the registered manager did not obtain references from potential recruit's current or last employers. The registered manager accepted references without referee's names or company details provided and had not verified that the references were authentic. This meant there was a potential for people to be cared for by staff who were not suitable.
● The registered manager did not question why some of the job applications did not have full employment histories with unexplained gaps in employment and instances where there were no explanations for leaving employment. The registered manager failed to follow this up with potential recruits at the interview stage and therefore could not be assured these staff were suitable to work with people using the service.

The provider's recruitment services were not robust and therefore did not protect people using the service from unsuitable staff. This a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last visit in February 2019 we found the provider allowed new staff to work with people before their criminal record checks from the Disclosure and Barring Service (DBS) had been completed. During this visit, we found the service carried out DBS checks before staff could start work.
● People and relatives made various comments about staffing levels. Comments received included, "There is not enough staff at the weekends", "Yes, when there was an incident where a resident had fallen, there were enough staff", "I never visited the home at the same time and there has always been enough (staff)" and "Yes there is (enough staff), that's another plus."

● Staff spoke to us about challenges due to staff sickness. This was followed up in our conversations with the general manager and the registered manager. They confirmed there was a shortage of staff due to long term sickness, maternity leave and general staff sickness. They had access to a small pool of bank staff but they only worked limited hours. Therefore, staff would offer to take on extra shifts to ensure shifts were appropriately covered. Management said they were in the process of making a proposal to senior care workers to provide on-call cover at the weekends. All staff had not yet been consulted with this at the time of our visit.
● The registered manager explained there should be 12 care staff on duty to cover the various shifts on a daily basis. We looked at staff rotas covering the period of October 2019 up to the last day of our visit. On 1 January 2020 there were nine staff on duty, 2 January 2020 10 staff, 3 January nine staff, 4 January eight staff and 5 January seven staff on duty.
● We noted some people experienced unwitnessed falls on days when staffing levels were low. This happened on 11 November 2019 when 9 staff were on duty and to the same person again, on 17 November 2019 when there were only eight staff on duty.
● We found the provider had not taken prompt action to put in interim arrangements to ensure they were enough staff to meet people's care needs, whilst on-going recruitment was underway.

The provider had not ensured there were enough staff on duty at all times. This was a breach of Regulations 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;

At our last inspection, we found a lack of up to date environmental risk assessments which left people open to the potential risk of fire and Legionella. Risk management plans lacked detailed information on what action staff should take to mitigate identified risks. This was a breach of Regulation 12 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

● We looked at the provider's annual fire risk assessment carried out on 16 July 2019 and related action plan. We saw some of the identified actions had not been addressed by the management team. We brought this to the attention of the registered manager. For instance, the fire risk assessor recommended a policy should be in place to state personal electrical appliances brought into the premises for use by staff would be subject to portable appliance testing (PAT) testing or not allowed to be used in the service. This had not been completed. After our visit, the registered manager sent us an updated fire policy which did not have the updated statement as outlined in the fire assessor's recommendation. This meant people were placed at potential risk of harm as the service did not act on recommendations to prevent fire.
● At our last visit in February 2019, we found management failed to ensure appropriate risk management plans were in place to enable staff to manage identified risks to individuals. We received assurances from the registered manager and general manager they would take appropriate action to address this.
● We looked at the care records of 10 people who had experienced falls, of which some had sustained serious injuries. We saw inconsistencies in the recording of falls and there was no documented information informing staff what action to taken to mitigate further risks of falls.
● For instance, one person had two falls reported on the 17 September 2019 and 13 November 2019. However, their 'personal risk screening tool update sheet' completed on 30 November 2019 reported there were 'no recent falls'.
● Another person's falls risk assessment recorded the person was at high risk of falls but there was no

management plan in place to show what staff should do to manage this risk. We saw there were similar inconsistencies in the records of four other people.
● We looked at the provider's 'fall/post fall policy and procedure' dated June 2019. This stated staff should complete a post falls assessment once a person had fallen. We saw no records of post falls assessments for any of the 10 people who had experienced falls. We spoke with the registered manager to find out where these completed assessments would be located. The registered manager informed us staff had not yet started to complete them. The staff training matrix showed no staff had undertaken falls prevention training.

Systems were not robust enough to ensure that safety was effectively managed. This was a continued breach of Regulations 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We spoke with the maintenance manager and viewed records relating to various health and safety tests undertaken. Legionella assessments were up to date and water tests regularly undertaken, this included weekly water temperature checks. Records showed the maintenance manager had carried out regular portable appliance tests (PAT) and gas boiler checks were up to date.
● Training records showed staff received fire safety training and regular fire drills happened. People had personal emergency evacuation plans (PEEP) to ensure their safe exit of the building in the event of a fire. The registered manager did carry out regular reviews to ensure people's current mobility status was up to date. We noted some people's PEEP had not been reviewed since 2018. We spoke with the registered manager who assured us this would be addressed.

Using medicines safely
● The service's 'drug administration policy' dated June 2019 stated medicines could only be administered by staff who had been assessed as competent by the registered manager to carry out the task. We looked at staff training records but could not determine if their competency to administer medicines had been assessed. We spoke with the registered manager and was informed this had not been carried out.

We recommend the service seek best practice and national guidance in relation to the completion of staff medicine competency assessments.

● Some people did not require support with their medicines. Where staff did administer medicines, people and relatives told us they were well managed.
● Comments from relatives included, "We have no worries (with staff administering their family member's medicines), "[Name of person]'s medicines were all upside down when she returned from hospital. [Name of deputy manager] was very helpful and sorted it all out" and "My medicines are given to me on the right time and right day."
● Medicine administration records (MAR) recorded medicines prescribed, dosage and times staff were to administer medicines. We saw the signatures of staff who had completed the task. An 'as and required' (PRN) protocol was in place. This ensured staff administered PRN medicines only when required rather than on a regular basis. At the time of visit, staff were not administering controlled medicines.
● Staff demonstrated good knowledge of their responsibilities in relation to supporting people with medicines and had attended medicines training.

Learning lessons when things go wrong.
● There were several reported incidents since our last visit, this included incidences of falls. We found no analysis of these incidences to pick up on any trends or emerging patterns to prevent further occurrences.

Therefore, the provider had missed opportunities for learning.

Systems and processes to safeguard people from the risk of abuse

● People said they felt safe from abuse. Conversations we had with relatives supported this. Comments included, "Absolutely, (family member is safe from abuse) yes" and "No problems at all."

● Staff knew how to protect people from abuse and explained to us the types of abuse people could experience and what signs (of potential abuse) they would look out for. Training records confirmed most staff had undertaken safeguarding training and this was up to date.

● A safeguarding policy was in place which was accessible to all staff and signage on how to report concerns was displayed in the staff room.

● The registered manager ensured all safeguarding incidents were reported to the local authority and statutory notifications regarding incidents were submitted to us but this was not always in a timely manner.

● When looking at how the service protected people from discrimination the registered manager told us, "Discrimination is unacceptable, and we encourage staff to confront anything if it is poor practice so that it can be dealt with in the most appropriate way."

Preventing and controlling infection

● People and relatives felt the service was clean and well maintained. Comments included, "(Family member's) room is always spotless", "No problems, excellent and always well kept", "I think it's definitely clean. I always see staff with gloves and aprons" and "10 out of 10 its spotless." Our observations of the service confirmed this.

● Staff records showed they had attended training in the prevention and control of infection.

● An infection control policy was in place and was accessible to all staff.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- At our last visit in February 2019 we found pre-admission assessments, designed to make sure the service could meet people's care and support needs, lacked detail. The provider assured us new assessments were being developed to provide an in-depth assessment of people's needs.
- During this visit, we found no further improvements had been made. Completed pre-admission assessments had minimal information regarding people's physical, mental, social needs and preferences, with no information about identified risks. There were no record of peoples' or their relatives' views or involvement in pre-admission assessments, even though most relatives told us they had been involved.
- A relative told us the service had undertaken an assessment of their family's needs prior to them joining the service but this was carried out without their involvement. This had caused the relative some concern as they had been their family member's main carer for some time and wanted to share information regarding their family member's care and support needs with staff.
- We brought this to the attention of the registered manager who explained why this had happened. The registered manager acknowledged this was not in line with best practice and assured us this would not happen again. However, they were not able to provide us with an explanation as to why there were no pre-admission assessment records for some people. This meant people could not be assured they would always be effectively cared for.
- The registered manager did not make sure pre-admission assessments documented people's protected characteristics such as their gender, race and sexuality as outlined under the Equality Act 2010. This was confirmed by the registered manager who told us, "Care plans are person centred to reflect the individual's choices and needs but we do not as yet have their equality, diversity and human rights (EDHR) recorded, I will amend this fact." This meant the service could not be assured staffs' working practices would prevent discrimination and protect people's their human rights.
- The service did not always make effective use of health and social care professionals to support people to achieve good health outcomes. For instance, the registered manager told us people had access to a private physiotherapist who visited the service on a weekly basis. As several people had experienced falls we spoke with the physiotherapist to establish what their involvement was in the prevention of falls. They informed us there was no specific protocol or procedures followed for falls and it was staff who identified people who required a physiotherapy assessment and intervention.
- We viewed a list of people who were seen by the physiotherapist every week, and saw no records outlining reasons for referrals and no indication of any link with their needs for falls prevention. The physiotherapist

explained they did not provide any training for falls prevention or education for the staff apart from specific joint sessions for people using the service when required. This meant the service did not always work effectively with other agencies to achieve good health outcomes for people.

● The registered manager told us they supported people with their oral hygiene. The provider's oral health policy stated an assessment was to be carried out within 48 hours of admission and should be included in the overall health assessment. It also stated all staff will receive training on how to undertake an oral assessment.

● We found no records of oral health assessments; oral health was not part of staff induction and training records confirmed, no staff had undertaken any oral health training.

●There were no detailed oral health care plans in place. The service used 'daily brushing record and mouth care, teeth and denture' forms to record if staff assisted people with their oral health or whether people were able to do this for themselves. We found information captured was minimal. We could therefore not establish if people received effective oral hygiene care.

Systems for assessing and documenting people's needs were not always effective. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us staff would ensure they had access to various health and social care professionals such as the GP, chiropodists and would also escort people to hospital appointments.

● The staff handover book showed reports of events that happened during the shifts and outcomes of health and social care professional's visits.

Staff support: induction, training, skills and experience

● People received care and support from staff who were not effectively inducted. For instance, the 'induction checklist' and a 'New staff shadow records' was used to show what tasks new inductees performed under the supervision of experienced staff. However, we noted these records did not show what tasks inductees performed well or what areas required further improvement.

● The provider's staff training and recruitment policies dated June 2019, stated new staff would have to complete a 12-week induction which also covered the 15 Care Certificate standards. The Care Certificate is an identified set of standards health and social care workers should follow in their daily working life.

● We were unable to locate any records to confirm new staff had or were completing the Care Certificate training. We spoke with the registered manager about this. They told us there were no records, as they had booked new staff to attend their level two diploma in Health and Social Care in February 2020 and this course covered the Care Certificate standards. This was not in line with the provider's policies on staff training and recruitment and we could not be assured new staff had an effective induction to support them in their role.

● The provider's 'staff training policy' stated before new staff could work on 'the floor' they must complete safeguarding and moving and handling training. The provider's staff training matrix showed most staff had completed their safeguarding adults and medicine training. However, new and experienced staff had not completed or were not up to date with moving and handling, health and safety, falls prevention, equality, diversity and inclusion, infection control training, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) training. We noted only five staff had completed end of life training.

● The registered manager informed us that for approximately a year, staff had access to nurses who provided 24 hour on-call support to care staff who were not medically trained. The registered manager spoke positively about this service stating it reassured staff when people became ill or sustained injuries. However, there were no written procedures to guide staff about when to contact the nurses for assistance and only a small number of staff had been trained on procedures to follow when people became ill or

sustained injuries.
● At the time of our visit, the deputy manager had just started a new programme of staff supervisions. We noted care staff received supervision from senior care workers and senior care workers received supervision from the deputy manager. A similar system was in place for hospitality and housekeeping staff. There were no records to show staff had received appropriate training to conduct supervisions.
● We noted staff had a long gap in between supervisions, in some staff files this was seven months. Where discussions were around staff performance, there was no records of supervision of how they were being supported to improve their performance.

People received care from staff who were not effectively inducted, trained and supported. This was a breach of Regulations 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person who is supported in their own home need to be made to the Court of Protection (COP). 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.

Ensuring consent to care and treatment in line with law and guidance
● At our previous visit in February 2019, we found mental capacity assessments were not fully completed and did not routinely relate to specific decisions. Management assured us further action would be taken to ensure staff followed the MCA code of practice.
● During this visit, we found no further improvement had been made as mental capacity assessments still documented people as lacking capacity, without clearly stating what specific decisions people were unable to make. We spoke with management team about this and found that they did not fully understand the requirements of the MCA to ensure they protected people's rights.

The management team did not act in accordance with the MCA where people lacked the capacity to make specific decisions. This was a breach of Regulations 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff gave good examples of how they obtained verbal consent from people. Care records showed consent to care and treatment was sought from people or those who represented them.
● The service made sure appropriate authorisation was sought when people's freedom needed to be restricted for their safety.

Supporting people to eat and drink enough to maintain a balanced diet
● Relatives told us staff made sure their family member's nutritional needs were met. A relative commented, "(Family member) is not a big eater and does not like to eat. They (staff) do encourage her to eat." However, during our conversations, a few relatives told us the food portions were too big. We fed this back to the registered manager who told us this would be addressed.

● Staff explained what they did to support people to eat and drink. For instance, a staff member commented, "You get to know in hand-over meetings who is not eating well. We have food and fluid charts to monitor those whose food and fluid intake is not good." A relative confirmed this and commented, "(Family member) went through a period when she refused to eat. They (staff) kept a record to monitor to ensure she was getting enough nutrients." Care records showed what people's dietary requirements were and how they should be met.

● We observed the lunch time activity. People were offered a wide variety of nutritional meals and ate their meals in a relaxed environment. They were either in conversations with each other or with staff.

Good

# Is the service caring?

## Our findings

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

At the last inspection this key question was rated good. At this inspection this key question has remained the same.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives positively spoke about the caring nature of staff. Comments included, "The girls (care staff) are great. If I am not well or unhappy, I can talk to them", "They (staff) talk to (family member) and listen to what they have to say" and "Staff are very sociable and treat (family member) like a friend. They (staff) know she does not like leaving her room, so they go in and have a chat."
- People and relatives said staff knew them well. Comments included, "I don't know their (staff) names or recognise their faces but they know me" and "They (staff) know (family member's) life history."
- Relatives told us there were no restrictions on visits and staff were very welcoming.
- Staff told us how they made sure their work practice did not discriminate against people. For instance, a staff member commented, "I treat people the way I want to be treated and how I want my family to be treated." This was further supported by the registered manager who commented, "As per our policies, discrimination is unacceptable, and we encourage staff to confront anything if it is poor practice so that it can be dealt with in the most appropriate way."

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

- People told us they were able to express their views and make every day choices in relation to their care. Relatives of people who were not able to express their views about care, told us they were able to communicate with the service via email or telephone on their family members' behalf.
- Staff told us people were involved and given choices in various areas such as, clothes they wanted to wear to meals they wanted to eat. The registered manager told us, "Staff are made aware of residents choice's and that they have a right to choose how they live their life."

Respecting and promoting people's privacy, dignity and independence

- People and relatives felt staff were respectful in the way they interacted with them and in their care practice." A relative commented "They (staff) always speak to (family member) directly and address them by their preferred name." Whilst another relative told us they had "No complaints."
- We observed peoples' room doors closed when staff carried out intimate care and when people wanted to have time alone or had visitors. Conversations with staff confirmed this was usual practice.
- People and relatives said the service promoted their independence. Comments included, "They (staff) know what I can and can't do" and "They (staff) allow (family member) to go around and do a little bit of dusting, so they can maintain their independence" and "(Family member can go where they want."

Requires Improvement

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

End of life care and support ; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection we made a recommendation for the service to seek advice and guidance for staff about supporting people with end of life care needs.

- During this visit we found management had sought some advice and trained five members of staff but there still a significant amount of staff who had yet to receive end of life training. We noted there were no night staff amongst those who had received the relevant training. Care records indicated where people or those acting on their behalf had chosen not to be resuscitated if their heart stopped.
- Following the inspection, the registered manager informed us that this information was kept in people's red bags as directed by the local Clinical Commission Group. However, the appropriate forms were not located in people's care plans, for easy access in the event of an emergency as directed by the general manager in a recent audit.
- The registered manager told us how the service treated people equally and fairly. They commented, "All our residents are treated fairly and equally, their preferences are recorded in their care plan when they move in and as staff get to know them over time their care is adjusted accordingly. All are treated to their personal preferences, residents are given the opportunity to take part when they want to, if a resident wants to do something other than what other residents are doing, for example, eat at a different time due to religious beliefs this would be accommodated."
- As the registered manager did not ensure pre-admission assessments contained in-depth information, we were not able to establish if the information in people's care records accurately reflected their preferences and wishes.
- Where people had changes in circumstances such as, were no longer able to mobilise and required the assistance of a staff member when mobilising, this information was not updated in their mobility care plans. We noted the dates of the most recent updates were November 2019.
- People and relatives told us they had not attended any formal reviews. For instance, a relative commented, "No formal meetings have been arranged. What I tend to do is always speak to [name of registered manager and deputy manager]." The registered manager confirmed they had not undertaken formal reviews of care. This meant people's care needs, preferences and wishes were not always considered and regularly reviewed to make sure they were still relevant.

This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People and relatives knew how to raise concerns. Comments included, "I would initially speak with [name of registered manager] or put it in writing", "I tend to go into the home but will put it in writing, if I have to", "I would speak to the (registered manager)" and "I would contact the [name of deputy manager and registered manager] via email or arrange a meeting."

● Where people raised concerns, they told us the service responded satisfactorily. We viewed the complaints register and found staff had not documented any complaints received.

● The service had a complaints policy however, this stated if people did not feel able to raise an issue with the service, people should contact the Care Quality Commission (CQC). There were no contact details for the chairman of the society, who would have been the most appropriate person to contact before people went to external agencies. We noted the Ombudsman's name was inaccurate and the policy did not explain to people the role of the Ombudsman and at what stage people should contact them.

The provider did not maintain a record of all complaints, outcomes and action taken in response to complaints. This was a breach of Regulations 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs

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

● The registered manager was aware of AIS and told us how the service met peoples' communication needs. They commented, "One of our residents has talking books to keep him up to date with current affairs. We have used flash cards and written down communication if there is hearing loss. If we need any extra help we would contact the relevant department, for example, a British Sign Language Interpreter."

● Care staff gave various examples of how they met people's communication needs. Care records confirmed what staff had told us.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People and relatives said the service met their social needs as they were able to participate in activities if they so wished to. For instance, a person told us they were happy to do their crosswords and other puzzles rather than participate in group activities. Social care plans were in place to make sure staff made sure people were not isolated and had the opportunity to participate in activities they were interested in.

● A relative felt more could be done to stimulate people as some of the activities only met the needs of a small number of people. We spoke with the registered manager about this, who explained they had recently recruited a full-time activity co-ordinator who would introduce a new programme of activities when they started work.

● The service had established good relationships with the local community such as local schools and nurseries, who regularly visited the service.

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 good. At this inspection this key question has 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

At our last inspection we found the lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of Regulation (17) 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

- After our visit in February 2019, the provider sent us an action plan dated 6 March 2019. This outlined the actions they would take to address the identified concerns and timescales for completion. For instance, the action plan stated, "The general manager would undertake monthly audits, following CQC standards."
- During this visit, through our review of records relating to the management of the service and our discussions with the registered manager and general manager, we found no quality assurance audits had been undertaken since April 2019. This was contrary to the general manager's monthly reports to the executive committee dated 19 September 2019 and 7 November 2019, which stated the general manager had completed quality audits of the service.
- Following the inspection, the general manager sent us a quality audit they had completed between the 31 July 2019 and 15 August 2019. The general manager's monthly reports to the executive committee dated 19 September 2019 and 7 November 2019, stated they had completed quality audits of the service. However, the nominated individual told us they had only received a verbal summary of the audits and not seen the documentation relating to these.
- The lack of audits of staff training, infection control, and care records showed the provider had failed to identify the shortfalls identified during our inspection. This meant the necessary improvements were not made to improve the quality of the service and protect the welfare and safety of people.
- Quality monitoring systems had also failed to adequately identify, monitor and address significant issues in relation to people falling and sustaining injuries in the service.
- Records relating to care and support were not always completed, accurate, or up to date. We observed this when looking at staff induction and recruitment records, pre-admission assessments, training records, minutes of meetings with people or those who represented them, care records and quality monitoring.

Quality monitoring systems were ineffective and did not protect people from inappropriate or unsafe care. This was a continued breach of regulation 17 (Governance) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
● The management team lacked an understanding of equality, diversity and human rights. This was demonstrated by their lack of understanding and failure to consider people's protected characteristics, in the planning and delivery of care.

We recommend the service seek national guidance and best practice in relation to adopting an equality, diversity and human rights approach to all aspects of delivery of care.

●Staff felt confident to report poor work practices to management and felt they would be listened to and appropriate action would be taken.
● We found the culture of the service was open and observed management were visible and easily accessible to people and staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives said they were able to give their opinions about service and felt listened to. The registered manager explained the activity co-ordinator obtained people's feedback, a conversation with a volunteer who had been working at the service for a number of years and had worked with former activity co-ordinators, confirmed this.
● We looked at the staff survey dated 2019 and saw staff provided feedback on various areas such as, the working environment, activities, staff treatment and staff coverage. An action plan was developed but we noticed some of the action points were statements rather than actions.
● For instance, two staff members felt they were not treated equally. The action point to address this was, "All staff are treated the same in line with policies and procedures." In our conversation with the registered manager and general manager about staff shortages, we found certain actions they had taken, had the potential for staff to feel they were not treated equally. The management team were very receptive to the feedback given.
● Systems in place to communicate how feedback was received did not always lead to improvements.

We recommend the provider reviews their system for responding to and acting on feedback about the quality of the service.

Continuous learning and improving care
● There was no evidence of the provider evaluating learning to improve care and as a result of this, we found multiple breaches of the regulations, some of which were repeated from our last visit.

How the provider understands and acts on the duty of candour (DoC).
● Where notifiable incidents happened, the registered manager was aware of and acted in accordance with the DoC. A DoC policy dated June 2019 was in place to make sure all staff worked in an open and transparent way.

● People and relatives commented positively about the service. Comments included, "I think they (staff) get the basics right", "The staff are excellent!", "Very well managed" and "I think they (the management team) are doing well. The staff are wonderful."
● Staff shared their thoughts about working for the service. Comments included, "I love working here, we

are a close team. I know if there's a problem I could go to any staff. Management are open and approachable", "Management are very approachable and have supported me 100%. We have a good working relationship" and "I think it is (well-led) but there is room for improvement.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider did not do everything practical to make sure people received person-centred care. People's preferences and wishes were not always considered, reviewed and met. People or those who represented them were not always involved in an assessment of their needs and preferences. The provider failed to keep a record of decisions made by people or those who acted on their behalf. People did not receive effective oral hygiene care.<br><br>Reg. 9 (1), (3) (a), (b), (d). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider continually failed to work in accordance with the MCA and its codes of practice.<br><br>Reg. 11 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider not maintain a record of all complaints, outcomes and action taken in response to complaints.<br><br>Reg 16 (1). |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider did not have effective recruitment and selection procedures that complied with the requirements of this regulation.<br><br>Reg. 19 (1) (a), (b), (2). |

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 18 HSCA RA Regulations 2014 Staffing<br><br>There were not sufficient numbers of suitably qualified, competent, skilled staff.<br><br>Reg. 18 (1). |

**The enforcement action we took:**

We served a Warning Notice