

Clarence Lodge (Great Yarmouth) Limited

Clarence Lodge

Inspection report

49-50 Clarence Road
Gorleston
Great Yarmouth
Norfolk
NR31 6DR

Tel: 01493662486

Date of inspection visit:
10 April 2019

Date of publication:
10 June 2019

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service: Clarence Lodge is a residential care home that is registered to provide accommodation and personal care to a maximum of 28 people. At the time of our inspection, 14 older people were living there, some of whom were living with dementia.

People's experience of using this service:

- The systems for checking the quality and safety of the service had again failed to identify where improvement was required. Audits were not sufficiently robust to identify concerns we found during this inspection. This put people at risk of potential harm.
- Medicines were not managed safely and people did not always receive their medicines as prescribed. Auditing processes were ineffective at identifying and resolving medicine issues.
- There was not always sufficient staff available to people due to other tasks they had to complete in addition to care duties, such as cooking and delivering activities.
- Records in relation to hydration, nutrition, and healthcare needed improvement.
- Care records were contradictory in places and did not always contain accurate information. This meant care and support may not be delivered effectively.
- The service was not following the principles of the Mental Capacity Act 2005. Best interest decisions were not always in place where people lacked capacity to consent to their care.
- We received positive feedback from people about the caring approach of individual staff. However, we also found that the provider's systems did not always support the service to be fully caring
- People did not always receive responsive care. Where people needed support on end of life care, information was not being gathered sufficiently to ensure people's wishes could be met.
- Staff were not always safely recruited; the provider did not always make sure checks were completed to ensure staff were suitable for the role.
- There was a lack of stimulation for people using the service. Several people said they would like to see improvements in this area.
- Some equipment and aspects of the premises were not clean. Some environmental risks had not been identified.

Rating at last inspection: At the last inspection the service was rated 'Inadequate' (Report published December 2018.)

Why we inspected: We inspected this service in line with our inspection schedule for services in special measures.

Enforcement: 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: The service remains in special measures. We will continue to monitor this service according to our inspection schedule in line with services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms 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?

Requires Improvement ●

The service was not always 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

Clarence Lodge

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: One inspector, one inspection manager, and one expert by experience carried out this inspection. 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: Clarence Lodge is a residential home that is registered to provide accommodation and personal care to a maximum of 28 people. At the time of our inspection, 14 people were living there. The Care Quality Commission 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.

Notice of inspection: This inspection was unannounced.

What we did: We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about and we received feedback from the local authority and professionals who work with the service.

During the inspection, we spoke with three people who used the service, and three relatives about their experience of the care provided. We carried out observations of people receiving support. We spoke with the acting manager, provider, care consultant, and two members of care staff who worked at the service.

We looked at five care records in relation to people who used the service. This included medicines records. We also looked at two staff files as well as records relating to the management of the service, recruitment, policies and systems for monitoring quality.

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our previous inspection in October 2018, we rated this key question as 'inadequate', and found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to the poor management of medicines, assessment of risk, and cleanliness of the service.

At this April 2019 inspection, we found that some risks were still not being adequately assessed and updated in a timely manner, and there were continued concerns in relation to people's medicines. This key question therefore remains 'inadequate'.

Using medicines safely

- There was a system in place for ordering and giving people their medicines as prescribed. However, a person's medicines had been changed by the prescriber on 29 March 2019. The service had still not obtained the medicines and made the necessary changes. Therefore the person was not receiving their prescribed medicines.
- Staff were trained and assessed for their competency to handle and give medicines safely. However, we found that one member of staff was not competent but they were still handling and giving people their medicines. This had not been identified by the competency assessments carried out.
- Medicines were given by staff and recorded on medicine administration records but these showed that for some people who were not having their medicines because, for example, they refused them or they were asleep. The service did not take action to attempt to give people their medicines later or refer the matter to the prescriber for advice to ensure people received the medicines they needed to maintain good health.
- We found some medicines in the medicines trolley that had been recorded as given to people. We also found containers of medicines and tablets that were unlabelled or out of date and we could not establish who they were prescribed for or the reason why they had not been given.
- Additional records were in place for the application of people's medicated skin patches to ensure safety but these were not always consistently completed by staff.
- Regular audits of people's medicines were completed at the service but these were ineffective at identifying and resolving medicine issues.

Assessing risk, safety monitoring and management

- One person's nutrition care plan stated that due to a medical condition they should not have too much fluid as this could be dangerous. There was no detail relating to how much the person's fluid intake should be restricted, or how staff should monitor this. The care plan went on to say that the person should have a good fluid intake.
- One person had a condition which meant they required their blood sugars to be monitored each day. Their care plan stated that if there was a high reading it could indicate an infection was present. We found

one reading to be particularly high, but there was no evidence that this was followed up. The acting manager confirmed this and was unable to find any information relating to this.

- Another person experienced a skin condition; in their skin integrity care plan it stated that steroid cream should be applied, but did not specify where. It also said that the person was at risk of pressure ulcers and that skin should be inspected daily. It did not specify where staff should check on the person's body or where this should be recorded.
- Some people experienced behaviours which challenged staff, but detailed guidance was not always in place for staff on how best to support people to reduce their anxiety and distress.
- The laundry room was not secured, and contained the main boiler which was hot to the touch. People could walk in, and potentially burn themselves if they came into contact with the boiler. This risk was highlighted at the last inspection. We also found laundry detergents were left out which posed a risk of accidental ingestion.
- Emergency plans were in place to ensure people were supported in the event of a fire. However, one person's mobility status had changed and their plan for evacuation had not been updated. We also found where one person needed a hoist to evacuate, that there was no detail relating to sling type to use so they could be moved safely and promptly.
- Water systems were monitored to prevent the risk of legionella and recent sample showed no bacteria was detected. However, it was not clear from the records if shower heads were being de-scaled, and we found one shower head had heavy limescale.

All of the above constitutes a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Equipment such as hoists and bath lifts had been serviced to ensure they were safe to use.

Staffing and recruitment

- People told us they did not always think there were sufficient staff on duty. One person said, "I think they [staff] are over worked. Sometimes I have to wait for the toilet and don't want wet pants. I like to be clean but sometimes you can't wait." Another said, "I think they could do with an extra one, and one more at night." A third told us, "Sometimes there are not enough [staff]." A relative told us, "I don't think there'll ever be enough. If I press [family member's] bell they [staff] do come quite quickly. When I get here they often have slipped down the bed and their feet will be pressed up against the foot board. I ask them [staff] to reposition [family member] and they soon do it. It can't be good for [family member] to be left like that."
- There were 14 people living at the service, five of whom required two staff to assist them if they wanted to move. There were four staff on shift during the day, and two at night.
- One member of staff on the late shift had to prepare hot food for supper, leaving only three staff to assist people. This meant that if two people (who needed two staff) needed support at the same time, there would not be sufficient staff to respond to their needs promptly.
- The senior staff member was responsible for administering medicines, which meant they were not always available to support the other members of staff with carrying out care tasks such as supporting people to go to the toilet.
- We observed one person asked staff for assistance to be moved from the dining area into the lounge, the staff member who was about to help another person said, "Sorry you'll have to wait [person] needs two staff."
- A staff member told us, "Some weeks are okay, other weeks some staff just go off sick. Sometimes people have to wait. Two staff at night is hard. If there was an emergency you would both have to deal with it, so there wouldn't be anyone available if other people needed help. There is one [person] who calls in the night regularly as well. 14 [people] isn't too high, but we have two people on the top floor, and eight on [first floor]

and four on ground floor."

- The layout of the building further impacted on staff being able to respond promptly.

The provider remains in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Recruitment procedures were not sufficiently robust to ensure staff were suitable for the role.
- One staff member had been employed in the service without the provider obtaining references, or checks on their previous employment. Where Disclosure and Barring Service checks showed issues, there were no risk assessments completed to ensure they were suitable to work in the service.
- Pre-employment checks were not sufficiently robust.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Improvements were required to ensure infection control procedures were followed. One stand aid hoist was visibly unclean. The footplates contained debris and had a build-up of dust on which indicated it had not been cleaned for a long period. We also found one wheelchair seat which had an ingrained spillage on it.
- We noted a malodour in the ground floor toilet, and the toilet was not clean. The floor was unclean with debris, rolled up clothes on the window sill, and the soap dispenser label was peeling off the container. The pedal bin would not operate resulting in the lid being handled after hands had been washed.
- Staff had access to personal protective equipment such as gloves and aprons, and were seen to use these when required. However, we found some were stored in close proximity to a communal toilet which posed a risk of cross contamination.
- The provider told us that staff had completed food hygiene training. However, the training matrix showed that many staff were overdue this training. We advised the provider to update the matrix to show an accurate record. Care staff regularly worked in the kitchen and served food, so this training was relevant.

Systems and processes to safeguard people from the risk of abuse

- Staff received safeguarding training. Staff told us the types of abuse they might come across in their work. One staff member told us, "There are various types of abuse, physical, emotional, or sexual. I would report to the senior, CQC [Care Quality Commission] or the local safeguarding team."
- There had not been any recent safeguarding referrals made by the service. The provider told us there had not been any incidents which would warrant a referral.
- The community medicines team had made a safeguarding referral due to their concerns in relation to one person's medicines.

Learning lessons when things go wrong

- The acting manager and provider had taken action to improve areas found as requiring improvement at the last inspection in October 2018. However, the service had not made sufficient improvements, and as a result remained in breach of Regulations.
- There was a more robust method of recording accidents and incidents which had occurred in the service.

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

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At our last inspection in October 2018, we rated this key question as 'requires improvement'. This was because staff training and supervision was not being completed at intervals to ensure staff had the necessary skills. There were also concerns around people's nutritional needs being met.

At this inspection in April 2019, we found some improvements had been made in relation to staff training and supervision. However, we found improvements were still required in relation to ensuring people's nutritional needs were met. We also found a new breach of Regulation in relation to consent. We have therefore continued to rate this key question as 'requires improvement'.

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 with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
- The service did not have a log in place of DoLS applications made so they could monitor when applications were made and ensure they were reviewed when needed. The acting manager told us there were currently four applications made, none of which had been authorised by the local authority.
- People's records did not always contain care plans relating to why the application had been made, and how staff should support people with this aspect of their care.
- One care plan stated that the reason for the DoLS application was that the person was unable to manage their personal care, medicines, nutrition, and toileting. This did not indicate that the person was being deprived of their liberty.
- There was a best interest decision reviewed in January 2019, stating that it was in the best interests of the person to encourage them to get up from bed to prevent pressure ulcers. Their mobility plan stated that it was in their best interests to be 'bed bound', as movement caused them pain. Information had not been correctly updated within the person's care plan which could cause confusion for staff delivering their care.
- Two people had a sensor mat in place (which alerts staff when the person attempts to move) yet there were no best interests decisions documented in relation to this restriction.

This constitutes a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities)

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

- At our previous inspection in October 2018, we found the provider to be in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we had concerns about how people's nutritional needs were being met.
- At this inspection we found that information in relation to people's nutritional and hydration risks were not always clear. The provider remains in breach of this regulation.
- Two people's care plans we reviewed stated that they had an allergy to eggs. Whilst information held in the kitchen on people's food likes and dislikes stated that they 'didn't like eggs'. This posed a potential risk of an allergic reaction if the person ate something containing eggs, such as a cake.
- The service did not have one consistent cook, and various staff members also cooked on the evening shift. Therefore, this information needed to be clearer.
- In the records for one person who was at risk of developing urinary tract infections, it stated that they must have 1040mls of fluid in a 24-hour period. In the action plan of the same record the figure stated 104mls. We looked at the fluid chart for this person and saw that they were consistently receiving less fluid than the recommended amount. On one day they received only 350mls.
- One person's hydration needs were not clearly identified, which due to a medical condition should have been, to ensure their health.
- We observed the lunchtime meal. Eight people were seated at the tables in the dining room, others ate in the lounge area. The tables had been set for lunch and soft drinks were served by staff. Individual plated lunches were brought from the kitchen by a member of staff. They told people what was on their plate and staff offered to cut up some people's food in order to make it easier for them to eat. Staff were present throughout the meal.
- One person who had lived in the service for several years was served peas and sweetcorn which they did not like. We noted they left half of their meal. Staff said they would record this in their food preference records.

Staff support: induction, training, skills and experience

- At our previous inspection in October 2018, we found the provider to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that staff were receiving relevant training and supervision.
- At this inspection we found that improvements had been made and the provider is no longer in breach of this regulation, though further improvements were required.
- The training matrix in place showed that staff had been supported to receive training relevant to their role. Where training was still overdue, we saw that training dates had been arranged for 2019.
- Observed practice and supervision of staff were now being completed, however, where further training had been identified, there were not always timescales for completion.
- Appraisals had been started, and included areas for improvement, again they did not always include a date to be completed by.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The service did not always work in a timely manner to ensure people's needs were met, and that they received the correct treatment. For example, one person did not receive their prescribed medicine despite it being available.
- People told us they were supported to see appropriate health professionals as required, however several people reported that they hadn't seen the podiatrist in a long time. One person said, "The staff sort things

out. The [podiatrist] hasn't been for ages, used to come every six weeks. I think they [management] are trying to get someone else. My feet could really do with being done." Another said, "The [podiatrist] hasn't been for ages. You can see the GP if needed." We followed this up with the provider after the inspection and they confirmed there had been a delay in finding a podiatrist, but recently one did visit and people had now been seen.

Adapting service, design, decoration to meet people's needs

- Best practice was not followed for people living with dementia. National good practice in dementia care, identifies that buildings accommodating people living with dementia should be designed and decorated in a way that supports people. For example, doors were not in a contrasting colour, nor were toilet seats and handrails.
- We found the first floor of the building was quite dark due to the choice of wall colouring. This could be difficult for people with sight loss to navigate.
- There was a second room at the back of the building which was a second lounge area which was intended as a quieter lounge where people could and read or watch television. However, this was quite busy as the manager's office was connected and staff also needed to use the space to access medicines, which were now stored there.
- The environment still looked in need of redecoration in some areas. Carpets on the first floor were worn. A relative commented on their family member's room, and the number of small holes in the walls where hooks and screws had previously been sited and needed filling or painting over.
- There were laminated posters showing a photograph and name of the occupant attached to bedroom doors which will assist people in recognising their own room.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care records contained information related to people's medical history, personal care, medicines, mobility, nutrition, and communication. However, some information was contradictory or required more information to ensure staff were able to deliver person centred care.
- People's needs and choices were not always delivered in line with the law. For example, best interest decisions had not been considered where people lacked capacity to consent to their care and where restrictions were in place.
- Assessments were obtained from health and social care professionals prior to people coming to live at the service. These were used to help plan people's care.

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

RI: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

At our last inspection in October 2018, we rated this key question as 'requires improvement'. This was because some aspects of people's dignity were not fully upheld, and the feedback from people living in the service indicated the staff approach could vary.

At this April 2019 inspection we received positive feedback from people about the caring approach of individual staff. However, we found that the provider's systems did not always support the service to be fully caring. This can be demonstrated by the concerns found in other areas of this report. We have therefore rated this key question as 'requires improvement'.

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

- All of the people we spoke with told us that the care staff were kind and caring. One person said, "The staff know me well and I know them, we have a laugh." Another said, "The staff treat us very well."
- We observed staff singing with people and providing comfort when they appeared upset or distressed. We did also observe that some staff were quite tactile with people at times. For example, we saw one staff member kiss a person on the head. Whilst the person did not appear at all upset by this and was seen to smile, some people may not be comfortable with this or may find it patronising.
- In the dining room we overheard a staff member complaining that they had to work until 10pm; people were present and were drawn into the conversation due to their close proximity. It is not appropriate for staff to be discussing negative aspects of the job and expectations of work with people using the service. This could cause people undue anxiety about the wellbeing of staff and guilt that they were being a burden.
- Relatives we spoke with told us they could visit at any time. This meant people were supported to maintain their relationships with those close to them.

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

- 'Residents' meetings were held monthly so people could give their views on the care they received. Minutes we reviewed were brief and did not always contain an action plan so it was clear that feedback was acted on or carried forward for further discussion.
- People were asked their views via a feedback questionnaire. Since January 2019, the feedback showed that several people had commented that they wanted more time for activities. The provider had started to explore this more fully by planning to create an activity schedule and looking at activity groups to gain ideas. However, care staff were still expected to deliver activity in addition to their care tasks, which at times was difficult.

Respecting and promoting people's privacy, dignity and independence

- People told us their privacy and dignity was respected. One person said, "If I want some privacy I can go to my room but actually sitting here [in the lounge] with my [relative] is quite private, nobody listens to what you're saying to each other. I feel respected, the staff are really good that way. It's nice, you can just please yourself here."
- Care plans included guidance for staff on areas of care that people could independently attend to, and how to encourage this. However, this was not consistent across the care plans. People did however tell us that staff encouraged them to do things for themselves where able. One person said, "I try to be as independent as I can be. The staff leave the bowl of water for me to wash by my bed and put my clothes on my bed. I get washed then and get my clothes on. It's the way I like to do things."

Is the service responsive?

Our findings

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

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

At our previous inspection we found the provider to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were not always accurately detailed and people had limited opportunity to participate in activities.

At this April 2019 inspection, we found that although care plans now contained more detail, some areas of people's care had not been updated to reflect their current needs or how their care should be delivered. This meant the provider remained in breach of this regulation.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Diabetic care plans were in place for some people. However, we found one person who required a diet to control their diabetes did not have a care plan. Staff had been taking blood sugar readings weekly but no specific care plan was in place to ensure staff knew how to support the person to manage their diabetes.
- One care plan stated that the person required blood pressure monitoring on a weekly basis. However, on the person's blood pressure log it stated that this had been stopped in December 2018. It did not explain why this had been stopped or who advised this was no longer needed.
- One person's nutrition care plan said they required weekly monitoring of their weight, whilst information contained within their skin integrity care plan stated monthly. We found their weight was being monitored weekly. However, this inaccurate information had not been identified after being reviewed. Similarly, one person's care plan for mobility stated they were at high risk of falls. However, their falls risk assessment stated they were low risk.
- In another person's records the falls risk assessment stated that they were at high risk of falls but in the associated care plan the risk was recorded as low.
- A continence care plan stated that the person was incontinent and that staff must stick to a toileting regime to promote their continence. However, the care plan did not specify what the regime was to ensure their assessed needs were met.
- Two care plans we reviewed referred to people by the incorrect name or wrong gender, which did not demonstrate that care plans were person centred or respectful.
- One person's mobility plan stated they should be 'double assisted with the use of a hoist'. It then went on to say the person was 'bed bound'.
- There was not a dedicated activity co-ordinator in the service. Activities were carried out by care staff each morning at 10.30am. There was no activity schedule on display so people knew what was happening on the day.
- We observed in the morning that a visiting therapy dog had visited the service which appeared well received. One staff member was supporting three people to make Easter cards, and people were seen to be enjoying this. However, the provision of activity required members of staff to have the time to perform the activities in addition to their care duties.

- We asked people if there was enough to do, or if they got bored. One person said, "I enjoy the activities. I like skittles and when we play 'higher or lower'. We've been making Easter decorations. I don't think there's as much to do now as there was." Another said, "You don't see a lot of them [staff]. [Member of staff] is very good, very nice. The staff don't chat, they're too busy." A third told us, "I don't do much. I enjoy the skittles and 'something beginning with', flowers and other things. It makes you think."

- The provider told us they were in the process of creating an activity schedule to display in the service, and had also been looking at activity ideas online. However, given this has been an area identified as requiring improvement since 2016, sufficient progress had not been made. Improvements are required to make sure that people have regular access to activities they enjoy.

End of life care and support

- The service had not developed their practice sufficiently in supporting people in relation to their end of life care. Planning ahead for when people may no longer be able to communicate their views regarding end of life wishes is sometimes called 'advance care planning'. This involves thinking and talking about how people choose to be cared for in the final months of their life.

- People's care plans contained a template for their end of life wishes. However, those we reviewed had not been completed to ensure people's wishes were known and that care was delivered in line with these.

- Staff had received training in end of life care.

Improving care quality in response to complaints or concerns

- The provider had implemented a complaints log detailing the nature of concerns raised and outcomes. However, we found that not all complaints had been added to the log.

- The complaints procedure that was available to people had not been updated, and directed people to complain to the previous registered manager who had left the service.

- We asked people if they knew how to complain. One person said, "I'd speak to the staff and find out what to do." Another said, "I would just tell my family and they would complain if necessary."

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- At our previous inspection in October 2018, we found the provider to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated this key question as 'Inadequate'.
- This will be the third 'Inadequate' overall rating the service has received. The provider has failed to achieve and sustain a minimum overall rating of 'Good'. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'.
- At this inspection in April 2019, we found the provider had been unable to make sufficient improvements to comply with Regulations. We found the provider remained in breach of five Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found two new breaches in relation to consent and safe recruitment.
- There was not a registered manager in post.
- Additional audits had been implemented to help the service identify where improvements were needed. However, these had not been effective in identifying issues we found during this inspection.
- The provider had implemented a more detailed audit that they completed. However, when we reviewed the audit for March 2019, some answers were too brief or did not answer the question fully. There was also no action plan completed as a result of their audit where improvement was identified.
- Care plans contained contradictory guidance, and this had not been identified by the auditing or review processes. The care plan audit template had not been completed when reviewing the care plans.
- The provider and acting manager's knowledge in relation to the Mental Capacity Act (MCA) was limited, and as a result people's care was not delivered in line with the principles of the Act.

The provider remains in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The service had worked with the local authority quality team and community medicines team. Professionals told us they did not always act promptly to rectify issues, such as ensuring people received their prescribed medicines. We found this to be the case also; issues raised about one person's medicines had still not been resolved.
- Organisations supporting the service continued to raise concerns about the quality of care.
- Since our last inspection in October 2018, the provider had recruited an external consultant to support

them in making improvements in the service. They had created an action plan with timescales for completion of work.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People who lived in the service had opportunities to provide feedback on the care they received. The provider had been doing monthly surveys since February 2019.
- We saw the results from monthly surveys all highlighted that people wanted more activity. The provider had not planned to recruit an activity co-ordinator until June 2019, or sufficient staff numbers to provide meaningful activities.
- Staff told us that they received team meetings. Minutes of these meetings showed that relevant items were discussed, such as improving documentation, infection control, and communication.

Working in partnership with others

- The service worked in partnership with the wider professional team. The service had also worked with the local authority quality team, and community medicines team. Professionals told us they did not always act promptly to rectify issues, such as ensuring people received their prescribed medicines.
- The provider needed to continue to forge links with other professionals and organisations that could support them in additional learning.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 to ensure that people's human rights were respected. 11 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not robust and did not ensure that staff were suitable for the role. 19 (1) (a)