Care UK Community Partnerships Ltd

Winchcombe Place

Inspection report

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Date of inspection visit:
29 January 2019
30 January 2019

Date of publication:
25 March 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:

Winchcombe Place is a care home with nursing which provides personal care and support for up to 80 people.

The registered manager of the home had left the service in December 2018, however was still registered with the Care Quality Commission (CQC). We were assisted by the management team during the inspection. The registered manager and registered provider are 'Registered Persons'. Registered Persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's experience of using this service:

●People did not receive a service that provided them with safe, effective and high-quality care.

●Risks to people's safety and well-being were not managed effectively and this placed people at risk of harm.

●Infection control was not always managed in an effective way.

●Incidents and accidents were not managed safely to prevent a reoccurrence.

●People's needs and preferences were not always assessed or person-centred plans developed to guide staff on how to meet people's needs.

●Staff did not always complete training in meeting people's needs and this meant people were at risk of inappropriate care and treatment.

●People were not always treated respectfully or in a way that promoted their privacy and dignity.

●Staff were not always deployed effectively.

●The service was not well-led and the governance system were not always effective and did not always identify the risks to the health, safety and well-being of people or actions for continuous improvements.

●Complaints had not always been managed appropriately.

●Appropriate referrals were no made to the local authority in a timely way.

●We were not always notified, as required by law, of notifiable safety incidents.

●Medicines management was not always safe.

●People told us staff were caring, although feedback received was that meaningful engagement was limited.

There is more information about this in the full report.

Rating at last inspection:

Good (Published on 4 August 2017).

Why we inspected:

This was a responsive inspection due to information we received of risk and concern regarding the safety and welfare of people living in the home.

Enforcement:

We have told the provider to take immediate action to address some of the concerns we found. 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 overall rating for this service is 'Inadequate' and the service is therefore 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 take action 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 take action 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our Well led findings below.	**Inadequate**

Winchcombe Place

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:

This inspection was carried out by four Inspectors and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:

Winchcombe Place is a care home with nursing which provides personal care and support for up to 80 people. 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 is set over three floors. The first floor is a dementia care specific floor. At the time of our inspection 75 people were residing in the home.

Notice of inspection:

This inspection was unannounced and took place on the 29 and 30 January 2019.

What we did:

Before the inspection we reviewed information we had received about the service. This included notifications the provider had submitted to us. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke to 12 people using the service and 14 relatives of people residing in the home. We observed staff with people in communal areas of the service. We spoke the interim home manager, the administrator, the maintenance worker, regional clinical nurse, operational support manager, deputy manager, two team leaders, relief RGN manager, lifestyle coordinator, housekeeping staff and 11 care staff members. We looked at eighteen people's care records and associated documents. We reviewed people's medicine administration.

We looked at the records of accidents, incidents and complaints, audits and quality assurance reports. We also looked at staff training records for all staff, the recruitment records and the supervision and appraisal records.

Following the inspection, we asked the provider for some further information which we received. This included follow up information on people's needs, staff disciplinary investigations and information related to the fire system and maintenance records.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management:

●We found risks associated with people's mobility were not managed effectively which exposed people to the risk of harm such as physical injury. We saw that one person had had multiple falls, some which resulted in serious injuries.

●We looked at this person's falls risk assessment, which had been reviewed nine times by staff between to dates of 02 June 2018 and 23 November 2018. However, the risk assessments were incomplete and in some areas blank, despite the person having sustained three fractures during this period of time. We discussed this with the management team who were unaware that this person's falls prevention had not been investigated to prevent recurrence. The registered person did not ensure this information was available to the management team to ensure that prevention measures were investigated.

●Following the third fracture, a falls risk assessment had been completed on 14 November 2018 by staff which stated the person was at "Low Risk" of falls. We reviewed this person's care plans prior to and following each fall and found that there was no evidence of any falls prevention in place. The care plan stated that the person "may need assistance" when mobilising.

● Risk associated to people's weight loss was not managed in a safe way. We reviewed one person's Malnutrition Universal Screening Tool which identified them as "High Risk" of malnutrition. The person had been weighed on a monthly basis by staff between July 2018 and January 2019. We saw that in a six-month period it had been recorded that they had lost 9.4kg. This was unplanned weight loss.

●The person's care records stated that a referral to the dietician was not made until December 2018, at which point the person had lost 7.9kg in five months. The management team advised they were still waiting for this person to be reviewed by the dietician following this referral.

●This person was being monitored in terms of their food and fluid intake on a daily basis. However, when we reviewed their food and fluid chart for the 29 January 2019 in the afternoon of that day, the person had last been offered food at 8.30am and there was no record of the person being offered anything else since that time. We discussed our concerns with management who were unaware of this but advised that it was a "recording issue".

● We saw during our inspection that people did not always have call bells within easy reach in case they should need to raise an alert for assistance. For example, we noted that a call bell in a communal area had

the cord tied up and was not at floor level and easily accessible. We saw in another communal area a call bell cord was placed on a grab rail and not lowered to floor level as it should have been. We raised this with management who promptly ensured they were accessible.

The registered person failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:

●People did not always have their medicines managed in a safe way. The registered person used a digital medicine management system (EMAR), which promoted more accurate medication administration records. The system would automatically prompt staff with actions and alerts about any discrepancies. Registered nurses and team leaders or senior care workers were responsible for the administration of medicines in the home. A nurse and a team leader we spoke with confirmed that they had received training in medicine management and the use of the EMAR system.

●Records seen confirmed that annual competency checks were required and had been undertaken. However, during our inspection we noted that staff had failed to remove a person's pain relief patch before applying a new one. This person therefore had two patches applied instead of the one. We raised this concern with the management team who advised they would conduct a prompt investigation.

●We reviewed an incident which took place in December 2018 relating to a medicine error where staff had failed to identify that a person had not received medicine to support them with their anxiety for two weeks. The information provided as part of the investigation stated that the medication had arrived under the generic brand name from the pharmacy and staff had rejected it on the EMAR system, not realising that it was the correct medication for the person. Staff had failed to raise this with the management team at the time and staff conducted no further investigation into this incident. When the management team were made aware, they notified the local safeguarding team and informed them the person's anxiety had increased as a result of not receiving this medicine. The management team stated that systems were now in place to prevent any reoccurrence of this type of error.

●We could not be assured that the registered person ensured staff were monitoring people taking their medicine. A relative told us about their family member, "We keep finding various pills dotted around in [name's] room which he has clearly had in his mouth and spat out, and I wonder how staff can be sure he is actually taking his medication."

The registered person failed to protect people from the risks associated with the unsafe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

●We observed a medicine round during the inspection and saw that staff conducted this appropriately, discussing with people the medication that they were administering. We checked the arrangements for the storage, recording and administration of medicines and found that this was satisfactory. Medication administration records were correctly completed following the administration of any medication.

Preventing and controlling infection:

● People were not always protected from the risk of harm in relation to the spread of infections. Two weeks prior to our inspection, we were informed by the registered person that people were experiencing vomiting and diarrhoea. Despite this, during our inspection we found that some areas of the home that were not clean. There was a malodour in some areas of the home, where there was a strong smell of urine.

● We noted that two communal toilets had what appeared to be faeces around the outside of the bowl and the other on the toilet seat. We reviewed the cleaning schedules for these two communal toilets and found that one had not been completed throughout the day and was blank when we checked it at 3pm. The other was last checked at 8am. We checked this several hours later and noted that it remained in the same state. We observed in the morning of the first day of our inspection that a bathroom hoist had some form of dirt residue on it and had failed to be cleaned when we returned at 4.53pm.

The registered person failed to protect people from the risks associated with the spread of infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Learning lessons when things go wrong:

● The registered person did not ensure effective systems were in place to investigate and monitor accidents and incidents. Records of accidents and incidents lacked detail and did not evidence that any monitoring took place of people after they had been involved in a safety incident.

●Accidents and incidents were not consistently reviewed to look for patterns or to check that effective measures had been put into place to reduce the chance of them happening again. Investigations into incidents lacked sufficient detail which meant that opportunities to learn from them were missed. In some cases, there had been no management investigation conducted.

●We saw that one person had fallen and sustained a cut to their face. There was no evidence that an investigation had taken place into this incident or any prevention measures were put in place to prevent recurrence. There was no further information regarding the injury and if staff would be monitoring the person to ensure that they had not suffered any ill effects as a result.

●We reviewed two separate incidents relating to staff members using restraint with people. For example, one staff member restricted a person from moving during personal care. The registered person had investigated this incident and took appropriate disciplinary action. The management team told us they have a "No restraint" policy. However, following this there was a second incident where a staff member restrained a person.

●This meant the registered person failed to ensure, where things had gone wrong, that information was available so that lessons could be learnt to improve the safety of the service for people.

The registered person failed to suitably assess risks to the health and safety of people who received care and treatment and to do all that was reasonably practical to reduce and mitigate such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staffing and recruitment:

● A formal tool was used to calculate the required staffing levels and this was reflected in the staffing rota and the number of care staff we saw during the inspection. During the inspection, we were informed by the

management team that, due to recent concerns, there had been an increase in staff deployed in the home. However, we could not always be assured staff were effectively deployed to keep people safe and meet their needs.

●.One person was highlighted as being at low risk of falls, despite them having a number of falls over a short period of time, some of which resulted in serious injuries. The registered person did not have oversight of these falls, and we could not be assured the dependency tool was being reviewed and reassessed where there had been changes in people's needs, or where risk of harm to people had been identified. Whilst the provider had increased the staffing levels as a result of the concerns at Winchcombe Place, there was no evidence to demonstrate how their deployment had been assessed, considered and applied.

●We reviewed an incident where a person had an unwitnessed fall on 25 December 2018 and sustained a head injury and was admitted to hospital. An action from this, identified by the provider, was that there must be staff present in the dining room at all times when people are in there. We noted on the second day of our inspection there were two people in one of the dining rooms and there were no staff present for a 15-minute period.

●Relatives told us there was not enough staff to keep people safe. One relative told us, "…there are not enough staff on the floor, especially at night [and] weekends." Another relative raised concern regarding the lack of staff present in communal areas. They told us, "I found my mother slipped down in her chair, almost to the point of falling out, with no carer in sight."

The registered person failed to consistently ensure that sufficient numbers of staff are deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The service kept recruitment records of staff. Records showed the registered person carried out Disclosure and Barring Service checks. Records also showed the service sought evidence of people's conduct in previous employments in the form of employment references. These checks identified if potential staff were of good character and were suitable for their role.

Systems and processes to safeguard people from the risk of abuse:

● Care staff had received training in safeguarding vulnerable adults. Staff we spoke with were able to describe signs of potential abuse and how they would report any concerns they had.

●We were told safeguarding concerns would be documented, reported to a member of the management team and they would then refer this to the local safeguarding authority. However, we found that appropriate referrals had not always been made to the safeguarding authority when someone was at risk of abuse. The local authority safeguarding team confirmed this.

●We had found that allegations of abuse incidents were not always reported in a timely manner to the Care Quality Commission as required under the Regulations and we have reported on this in the well-led domain.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were not met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience:

● People could not be assured that their needs would consistently be met by staff who acted with appropriate knowledge and skills when providing their care. Staff had received training that was considered mandatory by the registered person and were supported with an induction and with guidance of policies and procedures. However, staff did not always use the information about people's assessed needs to ensure they could manage risks effectively.

● A research based, nationally recognised assessment tool (Waterlow) was used to assess people's risk of developing pressure sores. For those reviewed, appropriate equipment such as pressure relief mattresses, and interventions such as positional changes, were in place and recorded in response to assessments.

● However, we found that the support being delivered by staff was not always in line with the person's care plan. One person's air mattress was found to be set at an incorrect inflation pressure for their weight. Their care plan stated that the mattress should be set between 4-5, but was found to be set at 3-4. Staff had been recording that they had checked the inflation pressure every four hours on a repositioning chart. The chart seen on the day of inspection had a pressure setting of 1.5 recorded by staff, which did not equate to any setting available on the mattress. Previous charts from the week prior to the inspection showed that staff had recorded a setting of 4-5 on six of the days and a setting of 1.5 for one day.

●Nurses had signed the repositioning charts at the end each day, and had not identified the pressure settings were incorrect. This meant staff were failing to ensure people's needs were consistently being met in relation to pressure care. We noted that not all staff received training in pressure care as mandatory. The management team advised that staff are now in the process of receiving training in pressure care.

●We saw some evidence that staff received one to one support from a manager in the form of supervision. However, these were not always frequent. A staff member told us they had attended supervision sessions in the past but added, "not for a while". They put this down to the recent changes in management staff in the home.

The registered person failed to ensure there were sufficiently competent staff who received appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014

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

●On the first day of our inspection, we observed the dining experience of one person at lunchtime who was at high risk of malnutrition. During a 30-minute period they were not encouraged by staff to eat their meal that was placed in front of them, despite there being significant concerns about their weight loss.

●We reviewed the person's food and fluid chart and found that the recording did not match what we had observed them eating. We asked a member of staff who was working in the dining room, what they had eaten during that time. The staff member was unable to clearly tell us what the person had eaten. This meant that staff were not accurately assessing and recording the person's food intake or able to ensure they were eating and drinking enough to maintain a balanced diet.

●People were offered a choice of food and drink. People's special dietary requirements were identified. Where people were at risk of choking through swallowing, we observed them receiving the correct consistency of food. Where people required pureed food, this was well presented. People told us that they enjoyed the food that was offered to them at Winchcombe Place. One person said, "Food is very good, usually a choice and they will do different things."

Supporting people to live healthier lives, access healthcare services and support:

● We saw evidence in people's daily notes that referrals had been made to specialist healthcare professionals such as a dietician, speech and language therapy and occupational therapists. However, relatives told us that they did not feel reassured referrals to specialist healthcare professionals were always made promptly to ensure their family members healthcare needs were being met.

●One relative told us that they had been asked by the staff to take their family member to receive specialist healthcare support. They stated, "I wonder what would have happened if I hadn't been around – would they have bothered to take him?"

● The management team promptly responded to this concern when it was raised. However, we could not be assured the registered person ensured they were always working well with healthcare providers to deliver effective care and meet people's needs in a timely manner.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be 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. The authorisation procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

●Staff knew the principles of the MCA and understood people's right to choose and sought people's permission before supporting them. During inspection, we saw staff gave people choices and encouraged and supported them to make decisions.

●The registered person had made DoLS referrals for people who had restrictions in place in relation to their care and support. We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw where the applications were due to expire contact was made with the local DoLS team as per their procedures.

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and respect:

●People were not always treated with dignity and respect. During our inspection we heard a staff member reference a person by their room number rather than their name. The staff member said to another staff member, "Put [room number] back to bed." This was said in a communal area where both people, relatives, staff and visitors could hear.

●Some relatives also felt their family members were not always treated with dignity and respect. A relative showed us photos of their family member's bedroom, where clothes were put in drawers screwed up and unfolded, and other clothing items placed on a desk and not put away.

●Another relative raised concern's regarding their family member. They told us when they visited their family member, "He was lying in a wet bed fully clothed in wet clothes. His room was filthy and clearly had not been cleaned and it smelled very bad – this is often the case."

●A further concern from a relative was, "I have found clothes in [name's] room which very definitely don't belong to him but have his name in them, including on occasion, ladies' blouses."

●We observed a person was left in dirty clothes where they spilt food on their clothes during the lunch period. This person was still in clothing covered in food spillage at the end of the day.

The registered person failed to ensure people are treated with dignity and respect at all times. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●Most staff were observed smiling throughout interactions with people and using touch appropriately to offer reassurance.

●Relatives indicated that staff would assist their relative in a task focused manner and would often not interact in a meaningful way. One relative said, "There is little to no dialogue, only with a few staff." During our inspection we observed staff supporting people in their bedrooms. However, this interaction was often limited and for a brief time before they moved to provide care to another person.

● People told us that they felt the staff were kind. One person said, "Very kind, very thoughtful." Another person told us, "Think they care okay. Can talk to people [staff] and get an answer."

●Staff had received training in equality and diversity. People told us that their spiritual needs were considered and they were supported to attend services if they wished. One person said, "I really enjoy the hymn singing. I used to go to church but I [now] go to the service here."

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

● People and their relatives told us they were involved in decisions about the care being provided. One person told us, "In the loop about [my] care." A relative said, "Meeting with the management about the care package."

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations have not been met.

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

● Care plans were not always person-centred and did not always contain details of people's choices and preferences.

●We reviewed people's care records and we found some care plans were not always clear and had conflicting information. For example, one person's care records stated "[Name] is not able to use her call bell". The care records then stated, "Staff to make sure that [name] has her call bell at any time she is in her room." This person's care records also stated that they were mobile and "independent." However, another section of their care plan stated that they were unsteady and unsafe walking. It was not clear from the information provided the support that the person needed. We spoke with a staff member who was unable to clarify the level of the support the person may need when mobilising. There was a risk that any new staff coming to work at the service could provide ineffective and unresponsive care, by following insufficient care plans.

●A relative told us, "Recently [name] was a resident of the day. Went through the care plan and found contradictions. Due to have a meeting to go through the report [care plan]."

●People had a booklet in their bedrooms which contained information on their history, background and personal preferences. We saw in one person's room this booklet was blank.

●During the inspection we saw a concern had been raised by a relative regarding their family member's care and treatment relating to nail care. The relative had raised concerns that their family member had not adequate nail care and they were in a great deal of pain. We saw a photo which clearly indicated they had not had their toenails cut or been seen by a chiropodist for a long period of time. This meant that the registered person did not do all that reasonably practicable to make sure that the person received person-centred care and treatment that is appropriate and met their needs. We noted that when the management team were made aware of these concerns, they acted promptly and referred the person to the chiropodist.

●One person required their nutrition via a percutaneous endoscopic gastrostomy tube (PEG). The person was not having any oral fluids due to their swallowing difficulties. However, there was no evidence that they were receiving any oral hygiene care. We spoke with two staff members who stated that they "tried" but the person did not like it. They said that they used a toothbrush. There were no records relating to this and no oral care equipment available for the person to ensure their oral hygiene was being managed appropriately. The management team advised they were going to be introducing appropriate oral care equipment to support in these instances.

●Another person's relative told us their family member was not receiving appropriate oral care for their dentures. They told us they had raised concerns "numerous times" but the issue remained the same. We observed that the person's toothbrush was dry and that sterilising tablets for the person's dentures remained unopened. We discussed this with management who could not assure us this person had received appropriate oral hygiene care, but advised they would investigate and ensure this was addressed.

●Activities were provided within and outside of the service. People were supported to participate in activities, as they chose. We saw a range of group activities was offered. People told us they were happy with the activities provided. One person said, "I join in with quite a few things; exercises, and games." However, we reviewed a folder for recording of activities residents had participated throughout the day and it was blank. We reviewed people's daily notes and were unable to always see what activities they had participated in which met their individual needs and social preferences to ensure they avoided isolation.

●We looked at a persons "Meaningful lifestyle" care plan. This contained a brief history and background of the service user. However, the care plan stated, "Many of the things [Name] used to enjoy she shows little interest in". The expected outcome for the service user was, "For [Name] to be occupied and stimulated in a constructive way" and "Staff to engage 1:1 session". This did not highlight what staff had explored in terms of the person's interests, choices and preferences. It did not provide guidance to staff delivering care as to the person centred approach they should take to ensure the persons choices and preferences were explored and met.

●We looked at this person's "Daily Living Records Report" and found that in the month of January 2019 they had only engaged in four 'activities'.

The registered person failed to ensure records reflected a clear care and treatment plan of people's individual needs and preferences. The registered person failed to consistently deliver appropriate person centred care and treatment that was responsive to people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns:

●There was a complaints policy in place however this was not always followed. Complaints and concerns were not always adequately managed and investigated by the registered person. The registered person did not always ensure there was a record of complaints and concerns that had been raised by people or their relatives.

●We reviewed the complaints folder and found there were 18 complaints logged. Where a complaint had been logged, it had been responded to appropriately. However, we spoke with the management team who told us, "We are now [ensuring people's complaints are investigated]." They went on to say, "There are more than that, but previously it appeared they were not always investigated properly." We found improvements in responding to complaints had been made by the management team.

●During the inspection process a number of relatives informed us they had raised concerns or made a complaint but they had not received an adequate response from the registered person. We could not find evidence that these complaints had been documented or responded to during our inspection.

●Relatives told us prior to the recent management changes they often never received a response following a complaint. One relative said, "Not informed when we made a complaint – things are improving now."

Another relative told us, "I had no Idea that I could approach them." One relative advised they had made a complaint and the, "reply was less than satisfactory."

The registered person failed to operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

End of life care and support:

● At the time of inspection, some people were receiving end of life care. People's care records contained information on included people's choices around their wishes in relation to resuscitation decisions and end of life care wishes. The records showed these decisions were discussed with people and, where applicable and relevant, their relatives.

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

There were widespread and significant shortfalls in service leadership. The registered person 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 the time of our inspection the service did not have a registered manager in post. The registered manager of the home had left the service in December 2018, however was still registered with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, they are Registered Persons. Registered Persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

●The registered person had put measures in place to ensure the service had adequate management support whilst they were recruiting a new manager. During the inspection, there was a deputy manager, a manager from another service, regional clinical development manager, operational support manager and relief RGN manager in the service. During the inspection, we found the management team to be accessible and transparent. There was a clear want to drive improvement within the service.

●Feedback from people and relatives raised concerns about the management of the home. One resident said, "Poor management". A relative told us, "It has deteriorated. Now picking up."

●We reviewed the registered person's "Quality Improvement Plan", which had been recently implemented since the change in management. This identified a number of concerns and actions that would be taken. However, it did not highlight all concerns found during the inspection. The management team advised they are regularly reviewing this document and action areas for learning to ensure that the service is continually improving.

●The registered person did not have an accurate understanding of risks associated with people. The inconsistent documentation meant that information was not reflective of people's needs, and this had not been appropriately picked up by the registered person. We found that whilst staff provided care to people, accurate records were not always maintained or did not accurately reflect the support people were being offered. This neither demonstrated good care nor illustrated how changes to people's needs were being managed. There was a risk that any new staff coming to work at the service could provide ineffective and unresponsive care, by following insufficient and contradictory care plans.

●During the inspection, we found the management team were not always able to answer our questions

related to documentation and incident and accidents. This was in part due to the recent management changes. It is important for the management team to have a thorough overview of the provision.

●The registered person did not have effective systems for monitoring and improving the service. The management team had recently re-introduced a clinical meeting where people at risk of malnutrition would be discussed and appropriate action put in place to mitigate such risk. We reviewed the minutes of the most recent meeting and found that not all people at "High Risk" of malnutrition were discussed, despite people's weight having decreased shortly prior to this meeting.

●We looked at the most recent "Weight loss log" that the management team were responsible for keeping up to date and found that out of the 19 service users deemed as a "High risk" of malnutrition, only five service users had any identified comments or actions. Two of which stated, "End of life". This meant that the registered person did not ensure the management team had sufficient oversight of the people at risk to ensure that those risks were being mitigated adequately.

●The registered person did not ensure the management team had sufficient oversight of accidents and incidents. Accidents and Incident forms had not always been completed and investigations and actions had not always been undertaken to prevent reoccurrence. Where actions were identified these had not always been followed up. At the time of inspection, we could not be assured that the registered person had completed audits on accidents and incidents to assess, monitor and improve the quality of the service being delivered to ensure they were keeping people safe.

● A falls analysis audit was conducted to identify trends and themes relating to people who had fallen and were at risk of falls. However, these did not consistently identify all people who had fallen and did not always identify where an injury had been sustained. This meant the registered person had no oversight of falls risk within the home. There was no evidence whether any actions had been identified and implemented as a result of this analysis to prevent recurrence.

●The registered person had failed to ensure that complaints were consistently managed in line with their policy and to assure themselves that investigation and action was taken. The registered person could not evidence that patterns and trends had been identified to understand how improvements could be made to the service, or that learning had taken place and shared with the staff group to improve performance.

The registered person failed to have effective quality assurance systems which meant that they could not always continuously learn, improve and innovate. Ineffective audits put people at risk of potential harm, as areas for improvement had not been addressed to mitigate risk. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

●Services registered with Care Quality Commission (CQC) are required to notify us of significant events, of other incidents that happen in the service, without delay. The registered person had not always notified CQC of reportable events within a reasonable time frame. This meant we could not check that appropriate action had been taken to ensure people were safe.

The registered person failed to notify the Commission of notifiable events, 'without delay'. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff:

● The registered person conducted regular quality assurance surveys with people, relatives, staff and professionals.

●We looked at whether people and their relatives were encouraged to give their views about the service they received. Resident and relative meetings took place periodically throughout the year.

●There was evidence that meetings with people and relatives had occurred, however further improvement was needed in the frequency of the meetings and to ensure relevant information about the home was shared appropriately with staff, people and relatives. One relative told us, "They never tell us when the meeting is being held." Another said, "They don't listen to our feedback."

Working in partnership with others:

● People's care plans contained records of visits or consultations with external professionals. Those seen included GPs, hospital consultants, dieticians, chiropodists and members of the community mental health team. However, feedback from professionals indicated that communication needed to be improved. The registered person also identified this as an action in their quality improvement plan.