Amica Care Trust

St John's Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Johns Court is a nursing home providing personal and nursing care for up to 42 people. The service provides support to younger and older adults who have a physical and/or sensory impairment. The service also supports people living with dementia. At the time of our inspection there were 34 people using the service.

St Johns Court accommodates 42 people across four separate wings, each of which has separate adapted facilities. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People told us they felt safe and supported by the staff who worked in the home. Staff recognised different types of abuse and how to report it, however staff did not always feel listened to when reporting concerns. We found mitigation of known harm was not robust and some people were not always supported to remain safe.

Potential risks to people's health and wellbeing had not been consistently identified and managed to maintain people's safety. We found areas of risk which had not been addressed sufficiently, such as management of falls, and environmental aspects. There were not always sufficient staff on duty to keep people safe and meet their needs. People's medicines were managed in a safe way, but storage of medicine required addressing. Areas of the home were visibly dirty and the management of Covid-19 was not always safe.

People's care needs had been assessed and reviews took place with the person and, where appropriate, their relative. New staff had not received an induction to ensure they were able to support people in a safe and effective way, while some training for existing staff's had lapsed. People told us they did not always enjoy the food offered, the provider was reviewing how people could be involved in the menu choices. People who lived with dementia were not always supported to eat their meals and have their drinks as staff did not always have time. Staff worked with external healthcare professionals and followed their guidance and advice about how to support people following best practice. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did support this practice.

People who lived with dementia were not always supported in a way which maintained their dignity. The dementia unit was not dementia friendly, with poor signage and lack of stimulation for people. The environment of the home was dirty and did not promote a respectful living environment. The provider could not be assured privacy was maintained for people's information as offices were seen to be unlocked when unattended.

People's care was delivered in a timely way, with any changes in care being communicated clearly to the

staff team. People told us they were supported and encouraged to attend the activities held within the home. People had access to information about how to raise a complaint. People's end of life care needs were met in line with their preferences in a respectful and dignified way.

People and relatives felt the management team had people's best interests at heart and felt the home and the way the service was run was good. However the staff team felt the previous management team did not listen or support them. Staff were positive about the new management team and felt they were already listening to them and making positive changes. The providers systems had not identified some concerns we identified on this inspection. Where the provider had identified areas for improvement these were not always acted upon in a timely way.

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 outstanding (23 October 2019)

Why we inspected
The inspection was prompted in part due to concerns received about people's care, staffing levels and management oversight. A decision was made for us to inspect and examine those risks.

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

You can see what action we have asked the provider to take at the end of this full report.
The overall rating for the service has changed from outstanding to requires improvement based on the findings of this inspection.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding's, people's safety, staffing and the providers governance systems.

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

For full information about CQC's regulatory response to the more serious concerns see the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will also meet with the provider 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

St John's Court

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
On the first day there was an Inspector, a Specialist Advisor with nursing experience and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Johns Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Johns Court is a care home with nursing care. 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. However the registered manager was in the process of de-registering as manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and five relatives about their experience of the care provided. We spoke with thirteen members of staff including the operations manager, the registered manager, the new manager, the deputy manager, the new deputy manager, nurses, senior care staff, care staff, the activities co-ordinator and the maintenance person. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two files in relation to recruitment and a range of files relating to training of staff. We looked at staffing rota's and staff allocation, along with incidents and accidents, complaints and safeguardings. Along with a variety of records relating to the management of the service.

After the inspection
We reviewed information the provider had sent to us, such as provider audits, resident's meetings and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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.

Assessing risk, safety monitoring and management

● Risks in relation to falls had not been fully assessed, reviewed and mitigated. Records showed that where some people required additional support, for example, such as having additional support from a staff member, this had not always been put into place. Without further review of how risk could be managed in a reasonable way, people continued to have further incidents. We raised our concern with the provider, who acted promptly to reduce the risk of further incidents. We also raised a safeguarding alert to the Local Authority.

● People who lived on the dementia unit were exposed to potential harm due to their access to the kitchenette area in the conservatory which held items which may pose harm to people. For example, the hot water dispenser was in a cabinet but this was not locked. Other equipment in the kitchenette area such as microwave, toaster and at mealtimes the hot trolley were accessible to service users. It was observed that staff were not always visible in this area. Staff told us how they would find one person dragging the toaster around the unit by the plug.

● There were aspects of the home environment which were not safe for people who lived with dementia. For example, the doors on the middle and top floor were push button release, the push buttons were visible and accessible to people who may not be able to assess the risk of harm. In addition to this, the home has a low wall and gate at the top of the staircase which poses a potential risk of a fall from a height. The provider could not be assured that sufficient measures had been put in place to mitigate the risk as far as reasonably practicable.

● Where one person was living with dementia and was at risk of falls, a sensor mat had been placed outside their bedroom door. However, the provider could not be assured this was practicable and sufficient enough to reduce the risk of them coming to any harm.

● Staff were aware of people's individual risks, however they were not always supported to do this in the safest way.

Systems had not been established to assess, monitor and mitigate risks to the safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection we wrote to the provider to seek reassurances relating to aspects of unsafe care. The provider responded and confirmed that key coded pads had been placed on the doors leading to the stairs to mitigate the risk of potential harm for people.

●People's individual risks associated to their health and clinical needs had been assessed and care plans

had been developed with the person, and/or their family involved. The risk assessments we reviewed were up to date and reflected people's current care and support needs.
● People we spoke with told us staff understood their care and support needs and had the help and support from staff when they needed them. Relatives also told us they felt involved in their family members care.

Systems and processes to safeguard people from the risk of abuse;
● Records showed incidents had taken place in the dementia unit of the home, however there was no clear plan in place to reduce the risk of these incident from happening again. While these incidents had been reported to the Local Authority, we saw further incidents had taken place. We raised a safeguarding alert to the Local Authority.
● Staff demonstrated a good understanding of different types of abuse and what approach they would take in the event of any concerns. Staff told us they had raised concerns about people's safety with the previous management team and had also raised concerns to the CQC as they felt sufficient action had not been taken. A provider representative told us they were aware of staff's concern and a new management team were now in place to ensure people's safety.

Systems and processes were not established and operated effectively to prevent abuse of service users. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concern with the provider, who acted promptly to reduce the risk of further incidents.

● People who we spoke with told us they continued to feel safe by the staff who supported them.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections. The registered manager advised all people had an essential care giver, however relatives who we spoke with were unaware what this meant, and had not been part of the weekly testing when this was in line with government guidance. The provider clarified that no relative had been an essential care giver, however some relatives told us they had continued to meet their relative during the outbreak period. This meant when family visited the home during the Covid-19 outbreak the provider could not be assured this was done so safely and in line with government guidance.
● We were not assured that the provider was using PPE effectively and safely. We saw examples where staff were not wearing gloves while carrying clinical waste. Staff told us that PPE was not easily accessible, such as gloves and aprons. We saw face masks were stored in different places, such as on top of radiator covers.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found areas of the home to be visibly dirty, carpets in the corridors were black and dirty, the carpet in the dementia unit was also dirty and stained, while carpet on the top floor was thread bare. High touch areas, such as door handles and buttons felt sticky. The tea and coffee jars in the kitchenette areas were visibly dirty. The worktops in the kitchenette on the ground floor had damage to a worktop which would be difficult to keep clean. In communal bathrooms we found damage around sinks which would be difficult to keep clean. In addition to this, we found drawers in a communal bathroom and in the pamper room which held dirty and used items, such as face masks and bed linen. Unlocked sluice rooms had clinical bags overflowing on the floor. We raised this with the provider on our first inspection day. A provider representative advised the carpets in the corridor and on the dementia unit were being replaced. On the second day of our inspection we saw staff cleaning high touch areas such as door handles and buttons.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Where outbreaks had occurred, these had not been analysed to understand where the

infection may have originated from, and how it had spread. Without reviewing this information, the provider could not learn for potential future outbreaks to help minimise the spread.
● We were not assured staff were always following the provider's infection prevention and control policy.

The provider did not have sufficient measures in place to assess the risk of, and preventing, detecting and controlling the spread of infections. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.

We have also signposted the provider to resources to develop their approach.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Staffing and recruitment
● The provider could not be assured they had sufficient staff to support people at night in the event of an emergency. We looked at the Personal Emergency Evacuation Plans (PEEPS) for people who lived on the ground floor, as the PEEPs for those people who lived on the middle and top floor were not available. We found that for the 17 people who lived on the ground floor, 13 people required two staff to mobilise them. In addition to this one person who lived on the top floor required two staff to support them down two flights of stairs. Rotas showed there were times when there were only three or four staff were working the night shift.
● The provider did not have sufficient staff to meet people's dementia care needs. Staff told us they were not available to provide people with the emotional support, prompting with drinks and supporting at mealtimes that people required. Staff told us that during the day there were only two staff supporting people with personal care, drinks and meals. We spent time in the dementia unit on the first day of our inspection and found staff were not able to support people with a positive mealtime experience as they were completing other tasks. In addition to this staff told us that a night there were times when one care staff member support people for the whole ground floor.
● Staff told us that due to people requiring two staff to mobilise them, people experienced delays in their care. One staff member told us how some people had their breakfast late, which was then close to lunch time and affected their appetite.
● A provider representative told us staffing levels were based on how many people lived in the home, rather than people's individual dependency needs. The provider representative advised us that there would be a review of how staff were deployed throughout the home. We were also advised that a business case was being drafted, to send to the provider for an additional staff member for the day shift.

There were not sufficient numbers of staff deployed in order to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they worked well as a team and supported each other to provide care and support to people.
● The provider had systems in place to ensure safe recruitment practices were carried out before employing staff to work in the home.

Using medicines safely
● Most people received their medicines when they should and people we spoke with understood the reason for their medicines. However, we did find that a person who required time critical medicine, did not always have these at the right time at night. We raised this with the management team who advised they would review this.
● People confirmed their 'as required' medicine, such as pain relief was offered.
● We saw staff carried out safe administration of medicines when supporting people to take these.
● People's prescribed drinks thickener was not stored securely. These tins were also unnamed to enable staff to identify who they were prescribed too.
● Improvements were required in relation to storage of medicines. Some medicines were stored in trolleys that was not in an air-conditioned room, the provider could not be assured this medicine was consistently kept at a safe temperature. We discussed this with the management team, who advised they were reviewing how medicines were being stored.

Learning lessons when things go wrong
● Safety concerns were not consistently addressed quickly enough. The systems for reporting and reviewing to drive improvement were not effective in ensuring safety concerns had been addressed adequately.
● When incidents happened, reviews and investigations were not always sufficiently thorough and required improvements were not always made.

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

Staff support: induction, training, skills and experience

- Staff who were new to the service had not received a comprehensive training induction. One staff member told us how they had not received fire safety training, medicines training, PEG training, catheter care but was providing this care and treatment. They expressed their deep concern they had been placed in this compromising position. The new management team were putting training in place as a matter of priority for those staff who had not received training. We found no evidence people had been harmed by this, and care records to guide staff in supporting people were robust.
- The provider was aware that staff had not maintained their training and development, and were putting plans in place to bring their training up to date.
- Staff supervision and support had not been consistent, staff told had they had not felt supported by the management team, with one person saying, "It fell on deaf ears". Staff told us that the new management team, even though it was their first week in post had been supportive and listened to their concerns.
- Staff told us there were times when there was not a good skill mix of staff on duty. For example, newer staff who had not received induction training, providing support to agency staff who had not worked at the home before. The provider was putting plans in place to ensure their staff group had the training and skills to ensure there was a good skill mix. The provider was actively recruiting new staff into the home.

There were not sufficient numbers of experienced or skilled staff on shift in order to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us staff were confident in their approach and had the knowledge and abilities to meet their individual needs.
- Relatives told us they were happy with the way their family members were cared for and were confident in the staff's abilities to care for their family member.

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

- People we spoke with said they had enough to eat and drink, however people told us the food was not to their liking. People told us they had raised this in resident's meetings. The management team were aware and were making plans to work with people to change the menus.
- We saw staff did not have time to support people who needed assistance with eating and drinking in the dementia unit of the home. While staff ensured people had sufficient to eat and drink, staff we spoke with were visibly upset that they were not able to spend quality time with people so they could enjoy their meals.

We raised this with the management team who told us they would look at how mealtimes worked for people.

● Where people required support to have nutrition through a Percutaneous Endoscopic Gastrostomy (PEG), which is a feeding tube through the stomach wall, we found this procedure to be well managed, with clear records and guidance for staff. However, we found that some staff had not received training, while other staff could not evidence they had carried out the training and were competent. The new management team where ensuring all staff had the right training and competencies in place.

● Records showed people maintained healthy weights, and any weight loss was monitored and reviewed. Management of people's diabetes was also well monitored.

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

● The premises did not fully support people who lived with dementia. Outdoor spaces were not fully accessible to people who lived on the dementia unit. For example, the outside area had items of interest, and we saw people wanted to go outside; however staff told us they could not allow people outside as there were trip hazards, such as the door threshold leading to outside.

● The kitchenette area in the dementia unit posed a potential risk to people, blinds were broken and staff were unable to close or open them properly. Staff also told us that the change in flooring, between the laminate in the kitchenette and the carpet in the dining area meant people thought there was a step, and increased their risk of falls. There was no clear signage for people or items of interest.

● The carpets in the main corridors were visibly dirty, the management team told us they were being replaced. We saw bathroom furniture was broken and damaged and toilet seats were loose.

● Where a person smoked outside, they did not have anywhere that was suitable to go to keep them dry from the rain. Instead we saw staff had tied an umbrella to the railings, we saw this was not a suitable for the person. The provider told us they had considered a more permanent fixture such as a shelter, however as this would change the appearance of the building this was not accepted under the conservation rules.

● The pamper room was used to store boxes, there were dirty and used items in draws, stale coffee in open jars and a fridge with grime in the bottom. The deputy manager told us this was not used anymore. We also found the hairdressing salon was unclean, with tobacco over the floor. The deputy manager advised there was a bar room for people to enjoy, however this was locked and we did not see anyone using this.

The premises were not always safe to use for their intended
purpose. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People confirmed they were supported to attend health appointments and the chiropodists, so they would remain well.

● Staff were aware of people's upcoming health appointments, and so ensured people were ready and prepared to attend these appointments on time.

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

● People's care needs had been assessed and planned in line with best practice.

● People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessment. Staff members could tell us about people's individual characteristics and knew how to best support them. This included, but was not limited to, people's religious beliefs, cultures and personal preferences.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

- People told us staff would ask for their consent before undertaking any personal care. People felt staff respected their wishes and listened to them. We heard staff seeking consent prior to supporting people.
- Where the registered manager had deemed people were being deprived of their liberty, applications had been sent to the local authority.
- The registered manager met their legal requirement to notify the CQC where a person had been legally deprived of their liberty.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported.

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

- People felt most staff treated them well. One person said, "I get on alright with them" adding, "Some I like better than others." A further person told us how staff didn't have time to do things for them, staff were rushed and the person was always looking for them.
- We saw staff did not always have time to support people with their emotional needs. Care staff were busy providing personal care and told us they did not always have time to spend with people. Staff told us they did not always have time to sit and talk and have meaningful conversations with people as staff worked with a task focused approach to their work.
- People told us that nighttime was noisy with the emergency bell repeatedly sounding loudly due to the fire exit door being opened. They also told us staff some staff were loud at night and they could hear them outside talking while smoking. The provider told us the call bell system was being changed so that it would not sound throughout the home, following the inspection the provider confirmed this work had been completed.
- Relatives we spoke with spoke highly of the staff, and felt confident the staff had their family member's best interests at heart.

Respecting and promoting people's privacy, dignity and independence

- People who lived with dementia did not always have their dignity maintained as incidents were happening to them without the support from staff.
- The environment of the home was dirty and did not promote a respectful living environment. The dementia unit did not promote a dementia friendly area, with poor signage and lack of stimulation for people. Due to staffing levels being low, where people wanted to go outside to the courtyard this was refused as staff said they could not keep them safe outside.
- People's records were not always kept securely, as office doors were left open or unlocked. Without protecting people's records, the provider could not be assured people's privacy was maintained.
- People we spoke with told us they were treated in a dignified and respectful way.

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

- People told us they were involved in their care and felt listened to.
- Relatives we spoke with told us they were involved and felt their views were listened to and respected.
- Staff recognised what was important to people and ensured they supported them to express their views and maintain their independence as much as possible.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- People who lived with dementia did not always have care personalised to them. We saw and staff told us that they did not have time to spend with people and we saw this impacted negatively on people.
- Staff were knowledgeable about some choices, but did not have the time to support people to fulfil them, for example, they were unable to support people sufficiently at mealtimes. We also found the food offered to people was not to their liking. One staff member said, "People here [the dementia unit] would be much better suited to finger food, but it's just not given as an option".
- People who we spoke with confirmed that staff understood their likes and dislikes.
- Relatives we spoke with told us they felt listened to. One relative said, "They know [the person's] likes and dislikes, as I filled in a lot of forms when [the person] came into the home, also over the time the carers have asked".
- There was a good level of information about people's needs and preferences recorded in people's care plans to guide staff.
- Staff told us they received a handover at the beginning of their shift, so they were aware of any changes to people's care and support since their last shift.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The registered manager had taken into consideration peoples communication needs when assessing and planning people's care. People told us they were happy with the way information was shared with them.

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

- It was recognised that due to the pandemic, staff had not been able to support people's social care needs as they had done so previously. The provider had adapted to this situation, to support social interaction as much as possible. For example, visiting pod had been built so that people could meet their visitors.
- Staff had supported people to maintain contact with family and friends through video calls. Relatives told us they also had access to a portal, which gave them information about what their family member had been doing that day.

● We saw people were engaged in interactive technology for different sports and games.
● People spent their day according to their wishes. Some people told us they preferred to stay in their rooms but were given the opportunity to go to the communal areas if they wanted. While other people preferred to visit the communal lounges.
● People in the communal areas told us there were always staff to talk with, and organised entertainment, such as crafts and cookery shows which people told us they enjoyed.

Improving care quality in response to complaints or concerns
● People we spoke with had no concerns or complaints.
● People and relatives we spoke with told us they knew how to raise a complaint if they needed to but were happy with the service provided.
● The registered manager had a complaints procedure for people, relatives and staff to follow should they need to raise a complaint. Where complaints had been received these had been dealt with in line with the providers policy and procedure.

End of life care and support
● We saw in people's care records that discussions had been held with people, and where appropriate their relatives about their end of life care wishes.
●We read comments from relatives expressing their thanks to staff for the support given during this time.
● Staff understood how to support people who needed end of life care and support. They sought support and worked with external healthcare professionals to ensure the right medicines and equipment was in place, should a person require these.

Requires Improvement

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 our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Support for staff from managers had been inconsistent, we found areas for improvement in relation to induction and staff training. The quality assurance checks had identified training had declined over the months, however it had not identified that new staff had not received an adequate induction into the service to ensure they were safe to work. In addition to this, the provider could not be assured the staff member carrying out competency checks had the most up to date skills to do so.
- Staff had told us they did not feel listened to when sharing the risks and issues they were facing to maintain people's safety. From what staff told us and records showed, we found people had experienced poor quality care for sometime. For example, a provider audit of people's experience of mealtimes in August 2021 found this to be poor and required improving. However, at this inspection we found the provider had not taken prompt action to address this as we found people's mealtime experience continued to be poor.
- The providers systems had not identified that mitigation of risk to people was not well managed. For example, senior management were not aware that one to one staffing had not been consistently provided to a person for months.
- The providers systems for ensuring the environment of the home was safe and in line with regulation was not robust. The provider had failed to identify various aspects of the environment which posed a potential risk to service users. For example, the window restrictors were not in line with Health and Safety Executive expected standards. We also found the maintenance room was cluttered with materials and accelerants were not stored safely. This had been identified as a shortfall by the fire service in October 2021, however action to remedy this had not been taken. We raised this as a concern on our first day of inspection, and this was resolved on the second day of the inspection.

Governance systems were not robust to effectively assess, monitor and mitigate the risks of the health, safety and welfare people and staff who use the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider updated us following the inspection, to advise the window restrictors had been reviewed and made safe so they were in line with the Health and Safety Executive standard.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff told us that the morale within the home had been low and said that some staff had left the service.

Staff had reported their concerns to senior management and the CQC.

● A provider representative told us they had listened to staff concerns and a new management structure was now in place. At the time of our inspection, it was the new managers first week. Staff told us that since the new management team had started morale was already improving as they found they were approachable, listened and addressed their concerns.

● People we spoke with knew there were management changes taking place, people we spoke with felt the management teams had been supportive.

● Relatives we spoke with were happy with the service, and felt they could speak to staff if they needed.

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

● The provider could not be assured that where incidents had taken place duty of candour had been applied. We raised this with the provider who advise they would review this and take action accordingly.

● The provider understood their responsibilities for reporting events and incidents that were legal required to the CQC.

Working in partnership with others

● The staff team worked with people, relatives and healthcare professionals to provide the good outcomes for people.

● Staff worked in partnership with external agencies to ensure people received a holistic service.

● There was a good approach to teamwork within the home. Staff told us they worked well as a team and said the new management team worked alongside them to provide support with caring for people. Staff told us they felt communication was improving between the staff group and the management team.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse of service users. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed in order to meet people's needs. This placed people at risk of harm.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems had not been established to assess, monitor and mitigate risks to the safety and welfare of people using the service.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Governance systems were not robust to effectively assess, monitor and mitigate the risks of the health, safety and welfare people and staff who use the service

The enforcement action we took:

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