HC-One Oval Limited

Mornington Hall Care Home

Inspection report

76 Whitta Road
London
E12 5DA

Tel: 02084787170

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Mornington Hall Care Home is a nursing home providing care to 107 people at the time of the inspection. The service can support up to 120 people. The home is divided into four communities, two for people with nursing needs and two for people without. Many of the people living in the home experience dementia.

People's experience of using this service and what we found
People and relatives told us they thought individual care workers were kind and caring, but were too busy to provide personalised care. People told us there were not enough staff, and those that were on duty were rushed. Records confirmed not enough staff were deployed to meet people's needs and we saw people's dignity was not always upheld. We saw interactions between staff and people were not positive.

People were not always confident staff knew how to do their jobs and did not think staff morale was good. Records showed the provider had failed to address our concerns about staff training.

Staff were not confident about the steps to take in response to allegations of abuse. The provider had not identified that complaints submitted constituted allegations of abuse. It was not clear that lessons learned from incidents were shared with the staff team, or actions put in place to reduce the risk of incidents recurring.

People told us staff supported them to take their medicines. Records confirmed this but the provider had not updated care plans to ensure medicines information reflected best practice guidance. Likewise, risk assessments had not been updated and we found cases where people were at risk as staff supported them in a way that did not reflect the advice of healthcare professionals. Staff were not always following the risk assessments that were in place.

People gave us mixed feedback about the food. While some people said it was tasty, others complained about the lack of variety. The chef told us the menu was prepared centrally and people did not get to choose what went on the menu. We observed mealtimes and saw there was not a pleasant dining experience.

People were unable to tell us if they had care plans. While some care plans had been updated, most had not. Those had had been updated were not improved and this meant people were at risk of not receiving personalised care. Activities provision was poor and people had very limited opportunities for engagement. Review records did not demonstrate people were involved in a meaningful way in making decisions about their care. Relatives confirmed they were told about people's healthcare appointments and records of healthcare professionals advise were maintained. However, their advice was not incorporated into care plans and risk assessments.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. There was no exploration of

least restrictive options and records regarding people's capacity to consent to care were confusing.

People and relatives told us they felt staff morale was low. Staff told us they did not feel supported by the management team. Despite our last inspection, local authority visits and their own audits identifying the issues found during this inspection, the provider had failed to take effective action to address the concerns. People and staff did not feel engaged in the development of the service.

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

Rating at last inspection and update
The last rating for this service was requires improvement (report published 29 March 2019) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating. We returned within six months as we had feedback from stakeholders that the provider was not making enough progress.

Enforcement
We have identified breaches in relation to person centred care, dignity and respect, consent, safe care and treatment, safeguarding, premises and equipment, staffing and governance.

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.

Special measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Detail are in our well-led findings below.

Inadequate

Mornington Hall Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors, a specialist advisor with expertise in nursing care for older adults, two assistant inspectors, a directorate support coordinator and two Experts 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
Mornington Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The provider told us the registered manager left the company 10 days after the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the action plan the provider had sent us after the last inspection. We reviewed the information we held about the service in the form of notifications they had submitted to us. Notifications are information about events that providers are required by law to tell us about. We also received feedback from stakeholders.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
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 spoke with 11 people who lived in the home and five relatives. We spoke with 18 members of staff. This included the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. The regional director, the registered manager, the night manager, the turnaround manager, the chef, an administrator, three nurses, a senior care worker and five care workers.

We reviewed the care files of nine people and checked medicines administration records in all the units. We reviewed the recruitment files for staff recruited since the last inspection. We reviewed the supervision and training records, activities records and various management and quality assurance records supplied by the provider. We reviewed staff and residents meeting records and feedback given to the provider. We reviewed records of incidents, accidents, safeguarding concerns and complaints. We reviewed various other documents relevant to the management of the service.

After the inspection
We requested additional documents relating to staff training, staff deployment and various analysis and audits. We continued to seek clarification from the provider to validate evidence found. We spoke with professionals who are involved with the service.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

At our last inspection the provider was not effectively identifying and mitigating risk and was not managing medicines or the risk of infection effectively and this was a breach of Regulation 12 (Safe car and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. The provider had failed to make sufficient progress and remained in breach of this regulation.

● The provider continued to use recognised tools to assess the risks faced by people in the receipt of care. Despite identifying issues with the quality of the completion of these tools and the measures in place to mitigate risks identified the provider had failed to take action to mitigate risks.
● The provider used a tool to assess the level of risk in relation to developing pressure wounds and skin damage. We found inconsistencies between the information contained in the risk assessment and the related care plan. For example, one person was identified as being at high risk of skin damage but their skin integrity care plan said they were a low risk. Another person's care plan and risk assessment contained conflicting information about their risk of choking. We also found records had been completed showing people had been repositioned when our observations were that people had not been moved. After the inspection the provider told us they had investigated the records issue and found staff had been recording repositioning incorrectly by recording the time they wrote the record rather than the time they supported the person to move. This meant people were at risk of harm as they had not been supported in line with their risk assessments.
● Where people needed support from staff to mobilise and transfer safely, there was insufficient guidance for staff to ensure they could support people safely. Care plans only contained information on the equipment and number of staff and did not describe how to support people to mobilise and transfer using this equipment.
● One person's risks had changed and a healthcare professional had recommended they should transfer with a hoist. The community they lived on did not have a hoist and staff confirmed they were supporting the person using a frame. This put the person and their staff at risk of harm.
● Other health related risk assessments were not being followed. For example, one person had a plan in place to monitor their blood pressure. Their blood pressure had not been recorded for a month despite the plan stating it should be monitored each week. Records showed the readings indicated medical advice should be sought, but this was not recorded. This meant people were at risk due to staff not responding to changes in risk.
● Measures in place to mitigate the risks of malnutrition and dehydration lacked detail. Risk assessments had not been correctly totalled and where the scores indicated a risk, there was conflicting information

where the comments suggested no risk. This meant it was not clear people were receiving the support they needed to mitigate the risks of malnutrition and dehydration. More details of the mealtime experience are including in the Effective section of this report below.

Using Medicines Safely

● The service had made improvements in the recording of medicines administration. The concerns we had previously found regarding administration records had been resolved. Medicines administration records had been completed and showed people had been given medicines as prescribed.

● People confirmed they received their medicines. One person said, "I have the same medicines all the time, but if any of them run out or I no longer take them, they tell me and explain why."

● People's care plans contained medicines care plans but these did not reflect best practice guidance and did not contain sufficient information to ensure people's medicines were managed in a safe way. The care plans simply described what level of staff support people needed to take their medicines. There was no guidance about side effects or the purpose of medicines. While in nursing units there were registered nurses who had professional training to enable them to manage medicines, this was not the case in residential units. This meant people were at risk of harm as not all staff had the information they needed to administer medicines safely and effectively.

The above issues with the quality and detail in risk assessments and medicines plans were a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● At the last inspection in February 2019 we had significant concerns about the prevention and control of infection. This was because areas of the home smelt strongly of urine throughout the day and the home environment was not always clean.

● Some progress had been made in this area. Most of the home was visibly cleaner and the sluice rooms were cleaner and better organised. Staff used personal protective equipment effectively and were seen to be washing their hands.

● However, the strong malodour we identified at the last inspection in one of the communities persisted. In February 2019 we had found the provider's own audits had identified this concern in November 2018. The smell was very strong and persisted throughout the inspection. Areas of this community smelt strongly of faeces throughout the day, including areas where people ate their meals. The provider had installed an odour control and air purification systems since our last inspection but this had not resolved the issue. After the inspection the provider sent us records to show they had approved replacing the flooring and completing a deep clean of this area.

The failure to properly maintain the environment is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff deployed to meet people's needs.

● People told us they had to wait "about half an hour" for staff to support them. A relative told us of their concerns that due to the location of their family member's bedroom they often were left until last to support. Another relative said, "They all have to wait." One person said, "They don't have enough staff. It takes time for them to answer a call because they are few and busy taking care of someone." A relative said, "I come here five days in the week to give a hand with [my family member's] care because they are always short of staff."

● Throughout the inspection we found people were left without staff support or supervision while in communal areas of the home. Members of the inspection team entered shared areas with over ten people in them with no staff visible.
● The provider used a dependency tool to calculate staffing needs on each community. These had been reviewed since our last inspection and each care file contained an up to date dependency assessment. The staffing level spreadsheet was specific that this related to nursing or care hours only, however, the registered manager confirmed that the six hours a day allocated on each unit to "other" staff was the wellbeing coordinator. On one unit when the wellbeing coordinator was not included each day was allocated five hours less than the dependency tool calculated as needed.
● The registered manager sent us the staff sign in sheets for each community so we could see how many staff had attended in comparison to the dependency and rotas. These showed that between 9 and 22 July 2019 fewer staff than were scheduled attended. On one nursing unit there were six days and four nights when fewer staff attended than the dependency assessment said was needed. On the other nursing unit there was one day and four nights when fewer staff attended than the dependency assessment said was needed. On the residential communities there were one day and three nights, and five days and three nights when fewer staff attended than the dependency tool said was required.

The above issues are a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Records of incidents and accidents did not always show the provider had taken appropriate action in response to incidents and allegations of abuse. It was not clear that incidents and allegations of abuse were being appropriately identified.
● For example, a relative had submitted a complaint which constituted an allegation of neglect. This was not included in the incident recording system and the complaints record did not include whether or not a safeguarding alert had been raised. The complaints record included a further five concerns which constituted allegations of neglect none of which had been raised with the local authority as safeguarding concerns.
● Staff we spoke with told us they would report concerns about people being abused to their line managers. However, they were not able to say what they would do if they did not feel their line manager had taken appropriate action. One care worker told us they would take action to resolve issues themselves. This meant people were at risk as staff did not know how to escalate concerns about incidents and allegations of abuse.
● Records of the actions taken in response to incidents were insufficient and did not demonstrate effective actions were being taken to prevent future incidents. For example, in response to the 14 slips, trips and falls from July 2019 only one resulted in referral to an external professional, none recorded updating or reviewing risk assessments. Most simply recorded that staff should monitor and observe people.
● The provider's tool completed an analysis which categorised the type of incident and meant it was possible to see patterns in the time and type of incident which occurred. Despite having this information available, which showed most incidents were falls, which took place in people's bedrooms either between 10am and 12pm or between 4pm and 7pm there were no actions in place to address these patterns.

The above issues with the identification and response to allegations of abuse and neglect are a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

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

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection in February 2019 we identified a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because capacity assessments were not clear and staff were not following the principles of the MCA. The provider had not made enough progress and this regulation was still in breach.

- The provider's audits confirmed they still had issues where people's capacity to consent to care and records relating to legally appointed decision makers were unclear.
- One person's care file contained a note that their relative had refused consent for a health intervention. The relative did not have legal authority to make decisions relating to health and welfare. Furthermore, the rest of this person's care plan suggested they had capacity to make this type of decision for themselves.
- Several people's care files contained conflicting information about their capacity to consent to their care. For example, we observed one person and saw they were unable to engage with communication from staff who knew them well and were largely unresponsive. They had a capacity assessment regarding their DoLS application but their daily notes stated they had consented to care and medicines each day. Another person's file contained a capacity assessment which stated they lacked capacity but all other sections of their file said they had capacity to consent to their care.

● While there were now capacity assessments in files where people were subject to DoLS, these were not specific and did not clarify what steps had been taken to facilitate people's involvement in the decision, and did not demonstrate that any less restrictive options had been considered.

These issues are a continued breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection in February 2019 we identified a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff hadn't received the training or support they needed to perform their roles. The provider had not made enough progress and this regulation was still in breach.

● The percentage of staff who had in date training for moving and handling people had deteriorated from 63% to 61%. Given the high number of falls we have reported in 'Safe' it was concerning that only 34.8% of staff had completed falls awareness training. In the 'Safe' section we described how staff were not following repositioning regimes for people who were at risk of skin damage. The training records showed that only 61.7% of staff had completed one module of the promoting healthy skin training, and this reduced to 37.5% who had completed all three modules.
● The provider's training records showed that the overall completion for their "compliance courses" those which were considered essential was 81.5%. The completion rate for the required training was 62.1%. Only 65.2% of staff had completed training in dignity which is reflected in the caring section of this report.
● In February 2019 we identified that staff supervision records were identical. We reviewed supervision records since the last inspection and found records were again identical. It was not clear whether staff were receiving group or individual supervisions.

The above issues regarding staff training and supervision are a continued breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider used standardised and recognised tools to assess people's needs. However, these had been poorly completed and did not lead to robust care plans which focussed on outcomes for people.
● One person's file contained multiple assessments which had been incorrectly totalled. For example, the tool used to calculate their risk of malnutrition had been incorrectly totalled which meant the assessment underestimated their risk of malnutrition. This person's oral assessment had included answers which the provider's tool stated staff should, "Take remedial action – clean mouth frequently, increase fluids, mark dentures. Review daily till changes resolve if needed make non-urgent referral to dentist / oral health team as per local process." There was no reference to how to support this person with oral care anywhere else in their file, and no dentist visits or input recorded in their professional visit logs.
● People's needs assessments and care plans did not reflect their choices. While staff were frequently instructed to respect people's choices, care plan did not contain details of what these choices were.
● The provider's audit had identified 47 priority care plans to reassess and re-write. Some of these had been completed and signed off by the registered manager as being of the required standard. We found these still lacked detail and did not contain enough information to ensure people received the care they needed in the manner they wanted. Records of care were inconsistent and did not demonstrate people were delivering care in line with their care plans.

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

● People gave us mixed feedback about the food. Some people told us they liked the meals. For example, one person said, "The food is OK. I like it." Another person said, "Some of the food is not too bad." However, other people told us they found the food difficult to eat and not to their taste. One person said, "The food is not very easy to eat." A relative told us, "I have to bring in food to [my relative] or he will go hungry because he cannot manage to eat the food they give him."

● The chef working during the inspection, who was not the lead chef within the home, told us the menu was devised centrally by the provider in order to ensure the nutritional value of meals. However, they recognised that this meant the menu did not reflect the cultural diversity of people living in the home. People had fed back to us, and to the provider in surveys that they would like more meals that reflected the different cultural backgrounds of people living in the home. After the inspection the provider told us about the work completed between the chef and the hospitality team to increase the variety within the menu to reflect people's preferences. This included the provision of approximately 27 meals a day which were religiously or culturally specific.

● People had eating and drinking care plans, and information about people's eating and drinking needs was shared with kitchen staff so they knew who required modified consistencies or additional calories. However, there was very little information about people's preferences and what information existed was contradictory. For example, one person's care plan stated they did not like chicken, but later on stated they needed their chicken cut into small pieces.

● We saw people were offered a choice of two meals as lunch was served. People told us they had not seen a menu in advance and did not have the opportunity to say what they would like to be on the menu. When we showed two people a menu they told us they had not seen it before and could not read it as the print was too small.

● Observations of mealtimes showed people who needed support to eat their meals were not given this in a sensitive or compassionate manner. At breakfast time we saw two people were supported to eat breakfast with no conversation, interaction or verbal encouragement. At lunchtime we saw one person was offered their choice from the menu and their meal served. The person did not eat any of their meal, and 13 minutes after being offered the choice their untouched plate was cleared away. They were not offered any support or encouragement to eat and were not asked why they had not eaten their lunch. Another person was sleeping and not eating their meal. A staff member woke them up to prompt them to eat their lunch, but did not stay with them. The person fell back to sleep and did not eat their meal.

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

● People and relatives told us they were supported to see healthcare professionals when they needed. A relative told us they were informed of health appointments so they could attend if they wished to.

● Information about the recommendations of healthcare and other professionals was contained within care files. For example, we saw a printed sheet of physiotherapy exercises at the front of one person's care file.

● However, information was not consistently recorded and was in different places within the files. For example, although the physiotherapy exercises were in the file, there was no reference to the support the person needed to complete the exercises within any of the care plans, and no record they had been supported to perform them within the daily notes. Likewise, where external nurses were involved in providing wound care, information about wound management plans was stored in different places and was not always easy to find.

● Visiting professionals recorded their input in a visitors record within each care file, but it was not always clear these recommendations were incorporated into the file. For example, recommendations about diabetes management had not been incorporated into their care plans. This meant people were at risk and led to confusion among the staff team. For example, two staff were asked about what they should do in

response to one person's blood sugar readings. The staff gave different answers and as there was no diabetes specific care plan it was not possible to easily check what staff should be doing.

The above issues with care planning, health needs and eating and drinking are a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Mornington Hall is a purpose built care home with large communal areas in each community with bedrooms along long corridors. The provider had decorated the ends of hallways with points of interest, including several decorated to look like libraries. Each community had a smaller lounge area for people who did not wish to stay in the large communal rooms or their bedrooms.

● Other than the persistent malodour in one of the communities, reported in the 'Safe' domain above, the home had been well maintained. The gardens were well tended to and we saw people sitting in the garden enjoying the sunshine during our inspection.

● There was a fault with one of the lifts during the inspection, and we saw the provider was working with their suppliers to rectify this, people were supported to access the building via an alternative route in the meantime.

● The large communal areas on each community were divided into dining areas and lounge areas with comfortable chairs. Although these areas felt separate due to their size and configuration staff did not seem to appreciate that the lack of walls meant noise in one part of the room would be heard in other parts. Throughout the day we saw these rooms had both televisions on and music playing simultaneously. This created a loud and confusing atmosphere which was potentially distressing for people living with dementia.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

At our last inspection in February 2019 we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not treated with dignity and respect by staff. The provider had not made sufficient progress and remained in breach of this regulation.

- During the inspection we made comprehensive observations of the care people were receiving. We saw people were not treated with dignity and respect and care staff did not demonstrate a compassionate or caring approach.
- One person was seen to be in distress, sobbing and apologising repeatedly. Other people were sat near them, and tried to offer comfort, but this was not successful. For 20 minutes this person cried and no staff attempted any interaction or offered any comfort. A member of staff arrived to start an activity, and while they introduced themselves to the other people, they did not attempt to offer any comfort or solace to this person. The person withdrew from the activity, turning in their chair and covering their face.
- One person was sitting in the communal area of one of the communities. Their catheter bag was clearly visible out of the bottom of their trouser legs. This showed a lack of care an attention and meant everyone in the room knew they were using a catheter when this was not necessary. We saw other people's catheter bags were clearly visible throughout the day.
- We saw a care worker went into a person's bedroom, moved their bed, turned on their television and then left the room, without speaking to the person at all. This did not demonstrate a caring attitude.
- On one community in the afternoon we noted one person still had crumbs from their lunch on their face and their clothing appeared uncared for. Their jumper had clearly been discoloured through washing. Both this person, and another person in that community sat next to a member of the inspection team and there was a strong smell of faeces. While it is possible this was from the chair they both sat on, rather than from their bodies, it is undignified to be in a position where people smell of faeces.
- In our last report we identified care plans did not include information about people's religious beliefs, cultural background, sexual or gender identity. There was no exploration of the impact these aspects of personhood had on people's experience of care, or their care preferences. This remained the case and it was not clear that any action had been taken to address this; updated care plans did not include this information.

The above issues where people were not treated with dignity and respect are a continued breach of

Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People gave us mixed feedback about how involved they were in making decisions about their care. One person told us staff had a folder about them, and another person said they did not know if they had a care plan. Other people told us staff asked their permission before offering them care.

● Care plan reviews contained a section for staff to record people's views about their care. At the last inspection in February 2019 we noted this was often used to record people's needs rather than their views. At this inspection we found people's views about their care were still not being captured. For example, one person's reviews stated for each care plan section and each month that they were, "Delighted to be involved to review." This does not say what their views on their care were.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

At our last inspection in February 2019 we found the provider in breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were not person centred and people's wishes for the end of their life had not been captured. The provider had failed to address these concerns and the breach continued.

● Both the nominated individual and the regional director told us they recognised the quality of care plans was not sufficient to provide personalised care. They had completed an audit which had identified 47 care plans as a priority to update. Each updated care plan was subject to review by the registered manager before it was considered completed. 19 care files had been updated and audited since our inspection in February 2019.
● We reviewed care plans that had been updated and audited and found the issues identified at the February 2019 inspection persisted. There was insufficient detail about how people wished to receive care. Specific details which were identified as being missing in our last report, such as preferred water temperature, product preferences or hair washing were still missing.
● The quality of records of care had not improved. They remained task focussed and there was no detail about how tasks were completed in a way that aligned with people's choices.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● The home now employed four wellbeing coordinators who facilitated group and individual activities for people who lived in the home. It remained unclear whether people had any involvement in choosing the activities. Records of individual activities showed people did not engage and there was no record that alternatives had been sought or offered.
● One person's records showed they repeatedly did not engage due to being asleep or watching television. It was not captured if staff attempted to engage with this person at different times to see if they might be awake enough to engage earlier or later in the day.
● There were activities schedules in place. The activity schedule for the week of the inspection included three sessions that were not activities. These were chocolate day, hairdressing and fruity Friday. This was discussed with the management team who recognised these were not activities and they told us given the very hot weather they were going to review whether chocolate day was an appropriate theme.
● The nominated individual told us they had recognised the home did not have a good understanding of the

opportunities for engagement with people living in the home. In order to start the development of this understanding they had introduced a programme called "Stop the Clock." This meant that at a set time each day every member of staff in the building was meant to stop what they were doing and spend 15 minutes interacting with people.
● People's relatives told us they were able to visit freely. Although several of them told us they felt they had to visit to ensure their relatives needs were met. This meant there was a risk that the social element of their relationships had become secondary to their caring responsibilities.

End of life care and support
● The quality of people's end of life plans had not improved. One person's file had been audited by the registered manager and signed off as completed but did not contain any information about their end of life wishes. Another person's plan stated they needed the support of their family to consider their end of life wishes. This showed that the provider was not prioritising supporting people to plan for the last stages of their life. This was despite one of the people whose file we reviewed being identified as receiving palliative care.

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

● People's needs communication care plans did not reflect how they communicated. For example, we spent time with one person whose communication relied on others responding to the tone, rather than the content of what they said. The person used very offensive language but it was clear they did not mean to offend. Staff confirmed they responded to the person's tone rather than actual words. However, their care plan stated the person could communicate their needs, choices and preferences "With confidence verbally." There was no reference to the actual words this person used, which some people may have found highly offensive. This meant their care plan did not reflect their needs and there was a risk staff who did not already know this person may not react appropriately to their use of language.
● The other care plans we reviewed contained a similar lack of detail about people's communication preferences. One person's care plan did not capture any of their preferences and relied entirely on their ability to communicate their needs. Their communication preferences were not described.
● Care plans were handwritten and stored in a locked office. There was no version of care plans that were available to people or in a format that was more accessible to them.
● The provider had not considered the accessibility needs of people living in the home. As described in the Effective section above, the menus were not accessible to people who did not have good eyesight.

The above issues with quality of care plans, activities and end of life planning are a continued 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
● Complaints were not consistently managed or responded to appropriately.
● People and relatives gave us mixed feedback about their experience of making complaints and raising concerns. One person told us, "If I have anything to complain about, I will go to see the manager and I am very sure it will be dealt with." However, another person said, "Nothing good comes from those meetings. What is the point?"
● It was not clear that the provider was completing a robust analysis of the complaints made. The provider

sent us a copy of their complaints log and analysis. This captured the nature of the complaint made and actions taken so far. The analysis page recorded, "No serious complaints reported." This was not correct as complaints had included concerns that should have been raised as safeguarding concerns and allegations of neglect and abuse.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last inspection we identified a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the audits and quality assurance systems had not operated to identify and address issues with the quality and safety of the service. Insufficient progress had been made and this breach of regulation 17 remained.

● The management team that had been new in post at our last inspection in February 2019 had not remained in post. While the registered manager remained, the clinical lead and deputy manager had both left. Two weeks after our inspection in July 2019 the provider informed us the registered manager had left the company. This meant here was a risk of a lack of continuity in the leadership of the home..
● The provider had submitted an action plan following our last inspection. This had set out the actions they would take to address our concerns and appeared robust. The action plan stated that issues would be resolved by 30 June 2019.
● Following further audits completed by senior managers from the provider they identified the action plan needed to be reviewed and updated.
● The current home improvement plan included detailed actions that were required to improve the quality and safety of the service. The audit updates had identified that actions relating to person centred care, dignity and respect, consent, safe care and treatment, staffing and governance were all behind their timescales with a plan to recover. The actions and plans were all to be completed or delegated by the registered manager. The actions that were off track had all previously been owned by the registered manager, in their absence it was not clear what support was in place to ensure the plan to recover would be effective. After the inspection the provider submitted an updated action plan which reflected immediate changes in the management structure which had been made following our inspection feedback.
● The provider had failed to identify that insufficient staff were being deployed to meet people's needs.
● Despite the issues being identified in February 2019 the provider's action plan had not resolved any of the breaches from the last inspection and new issues had also emerged. When the provider was given feedback that there was concern that no progress had been made between the inspections the nominated individual said they felt there had been progress as staff were no longer observed shouting at people who lived in the home. This was despite our observations showing people continued to receive an uncaring service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People and relatives told us they did not think staff were happy in their roles or well supported. One person said, "The staff are not happy, they are not well supported by the management, you can see that in the way they work" Another person said, "They've got really good staff; they don't support them"
● While staff told us they liked the registered manager, they did not feel the home was being well managed or they were being supported to improve in their roles. One member of staff said, "She tries. She works very hard. Sometimes the job is too much for her. I think it's too much work for her." Other staff told us they did not feel there was enough support for care workers and that the management team was not responding to their feedback about staffing levels.
● The provider had put in place additional management support, with weekly visits from the regional director and nominated individual as well as recruiting a dedicated manager for nights and putting in place a 'turn around' manager in the communities where we observed poor support at our last inspection. The feedback above demonstrates that the impact of this support was limited and was not perceived as supportive by the staff team, or people living in the home.

The above issues with the culture and quality assurance systems in the service are a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 complaints audit submitted by the registered manager stated they offered apologies to people and their relatives when investigations showed the complainant had raised valid concerns.
● Relatives gave us mixed feedback about whether or not they were contacted when incidents took place. One relative said they were contacted quickly but another relative told us they had not been informed about an incident in a timely manner.
● Incident records and the analysis did not record whether or not staff were offering apologies and communicating with people and their families in a transparent manner when things went wrong.
● Our review of incidents and complaints showed the provider had not submitted notifications to us regarding injuries, police attendance and safeguarding alerts as required. This was compounded by the fact that they had not identified safeguarding allegations in the complaints made. The nominated individual told us they had identified the service was under reporting incidents. After the inspection notifications were submitted for the incidents identified during the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff gave us mixed feedback about the opportunities they were given to be engaged with the development of the service.
● Some people told us they were involved with meetings where they gave feedback about the service. However, other people told us meetings of this type did not happen.
● Likewise, some staff told us they attended staff meetings where they were able to give their opinion but other staff told us they had never been invited to a staff meeting. Records of staff meetings showed they focussed on record keeping and did not provide an opportunity for staff to offer feedback about the service.
● The provider had completed surveys with people and relatives. These had been completed in June 2019 and there was no plan in place to respond to the feedback received. After the inspection the provider told us they were going to run the survey again as they had had a low response rate.

Working in partnership with others
● Feedback from external professionals about the ease of working with the provider varied. Some

professionals told us they felt they had positive working relationships with the service. However, others told us they found the provider was defensive and did not respond to feedback in a constructive manner.

● In our last inspection report we noted that the limited capacity of the management team had an impact on the service's ability to demonstrate partnership working with other organisations. This remained the case as the management capacity of the service had not improved.

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 11 HSCA RA Regulations 2014 Need for consent The service had not followed the principles of the Mental Capacity Act. Regulation 11(3)

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 had not operated effectively to identify and respond to allegations of abuse. Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises had not been appropriately maintained. Regulation 15(1)

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Needs assessments, care plans and care delivery were not personalised to people's individual needs. Regulation 9(1)(3)

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not being treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We have imposed conditions on the provider's registration.

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	Risks to people were not clearly assessed or mitigated. Regulation 12(1)(2)

The enforcement action we took:

We have imposed conditions on the provider's registration.

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	Systems and processes had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17(1)(2)

The enforcement action we took:

We have imposed conditions on the provider's registration.

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 Insufficient staff were deployed to meet people's needs. Staff had not received the training they needed to perform their roles. Regulation 18(1)(2)

The enforcement action we took:

We have imposed conditions on the provider's registration.