HC-One No.1 Limited

The Elms Care Home

Inspection report

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Date of inspection visit:
30 June 2022
12 September 2022

Date of publication:
08 December 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Elms Care Home is a care home that provides personal and nursing care for up to 37 people living with dementia. The home is in one adapted building over two floors. At the time of our inspection there were 29 people receiving the service.

People's experience of using this service and what we found
The service was not well-led. The registered manager and provider failed to carry out their regulatory responsibilities. Quality assurance processes were ineffective, this meant people were exposed to unnecessary risk of harm. The provider failed to deliver safe and effective care and had not always taken the action they said they would to improve the service people received.

People were not always protected from harm because staff did not always ensure they received care and treatment in a safe and effective way. People did not always receive their medicines as prescribed. Staff did not always seek prompt medical advice after medicines errors occurred.

People's needs were not effectively assessed or reviewed, and their care was not always planned in line with best practice guidance. People's health conditions were not monitored in line with guidance and necessary referrals were not always made to external healthcare professionals. People were not effectively supported at the end of life. People were not always supported to make informed decisions about end of life care in a person-centred or timely way.

Staff did not always safeguard people from harm and had not referred all potential safeguarding events to the local authority in line with the local authority's protocols.

People experienced delays in receiving care and staff felt rushed when providing care. The provider was highly reliant on the use of agency workers and resulted in people not receiving consistent care. There was no reliable record of the staff who had worked in the home. We therefore could not be confident of who provided care or was present in the home on any given date.

People's fluid and food intake was inconsistently managed. Despite the provider's assurances, we continued to find these records were not satisfactorily completed and we therefore could not be confident people were receiving sufficient fluids.

Staff received an induction when they were first employed at the service. However, they did not always receive an induction when they were promoted into new roles within the senior team. This meant staff did not always know and understand the provider's systems or their responsibilities. Not all staff had completed relevant training within the provider's expected timeframe. The registered manager was addressing this and had written to staff with short timescales for completion. Staff did not feel well supported by management.

People were not consistently supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were not always treated with dignity and respect or their independence promoted.

People told us they liked the food and were given choice at mealtimes. Some people told us they could make decisions about their day to day lives, such as when they got up and went to bed and how they spent their day.

People who were able to access communal areas told us they had opportunities to pursue interests and join in communal activities. Some people told us they liked the staff. They described staff as good and kind.

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 20 September 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations. The rating has changed to inadequate.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection and was prompted by a review of the information we held about this service.

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.

Enforcement and Recommendations
We have identified continued breaches in relation to safe care and treatment, and good governance at this inspection. We have identified new breaches at this inspection in relation to safeguarding people from abuse, staffing, person-centred care, nutrition and hydration, and dignity and respect.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Elms 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. 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
The inspection was carried out by two inspectors, a medicines specialist, 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
The Elms Care Home 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. The Elms Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 30 June 2022 and ended on 12 September

2022. We visited the home on 30 June 2022 and 4, 14, 20, and 26 July 2022.

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 commissioners of the service. We used information gathered as part of monitoring activity that was completed on 14 October 2021 to help plan the inspection and inform our judgements. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
During our visits we used observations to help us understand the experience of people who could not talk with us. We spoke with nine people who received the service, and two of their relatives. We received feedback from an external social care professional and local pharmacist who had contact with the service.

We spoke with 22 members of staff. These included care staff, senior care staff,, catering staff, administration staff, nursing staff, three of whom were employed by an external agency. We also spoke with the deputy manager, the registered manager, two interim home managers, five area directors, a practice development nurse, a senior clinical oversight manager, and a managing director. We also spoke by telephone with another managing director and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. These included sampling seven people's care records, multiple medication records, and two staff files in relation to recruitment checks. We also looked at a variety of records relating to the management of the service, including staff rotas and training records, meeting minutes, audits, quality assurance reports, and action plans.

Inadequate

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 requires improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had not always protected people against the risks associated with medicines management. This was a breach of regulation 12 (2) (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Using medicines safely

- The provider did not manage medicines safely. This meant some people may have been harmed and others were at significant risk of harm.
- Despite receiving repeated assurances from the provider during our inspection, we found multiple occasions when people had not received their medicines as prescribed. People had not received their prescribed medicines because they were out of stock. For example, one person had not received their anti-coagulant medication for 13 days.
- The provider did not take prompt action when people refused their medicines or were unable to take them. A person's care records showed they needed medicines in liquid form to be able to swallow them. They were prescribed antibiotic capsules and there was no evidence staff had requested the medicines in a form the person could take. Records showed the person did not receive the antibiotics as prescribed to treat the infection and their health deteriorated.
- The provider did not ensure people received the correct dose of medication. One person's medicine was increased by their doctor. However, when the new dose of medicine was received into the service, staff had administered both the old and the new dose for three days until an external professional identified this. Another person received half the prescribed amount of pain relief. This put people at risk of overdose and poor health outcomes.
- Staff did not always seek prompt medical advice after medicines errors occurred. For example, one person did not receive a medicine for three consecutive days, but staff did not seek medical advice until a week after they missed the first dose.
- Where medicines were administered through patches applied to the person's skin, systems were not followed to ensure the site of administration was rotated and the previous patch removed. This could cause the person to experience skin irritation and may have affected the absorption rate of the medicine leading to a variable dose of medicine being administered.
- Staff did not have sufficient guidance on where to apply medicines applied directly to people's skin. Records did not show people received topical medicines as prescribed.
- During our first two inspection visits we found the medicines trolley unattended and unlocked. This placed people at risk of accessing medicines that could cause them harm.

● After the first day of our inspection the provider told us that daily medicine audits would be carried out until safe practices were established. However, we found audits were not carried out in line with this action plan and were not always fully completed or effective.

Assessing risk, safety monitoring and management
● Risks to people's safety were not always assessed or reduced. This placed people at risk of harm.
● The provider failed to ensure systems were followed to help people maintain the condition of their skin. Monthly reviews of people's skincare needs did not always take place and thorough skincare assessments were not always carried out, and/or recorded, where people were at risk of pressure damage. Staff had not taken action when people's skin care needs changed and had not always escalated concerns to external healthcare professionals in a timely manner.
● Equipment had not always been sought, utilised, or used correctly, to help reduce risk or harm occurring. For example, pressure relieving equipment.
● Staff did not always support people to move safely. Two staff were supporting a person to move using a hoist. During the manoeuvre one staff left the room, and a lone staff member continued the manoeuvre. This was not in-line with the person's risk assessment and the person was at risk of an accident.
● People's health conditions were not monitored in line with guidance. For example, we found two people's blood glucose was not tested in line with guidance. This put people at risk of harm because meant they may not have received appropriate treatment. The provider put systems in place to address this after our first visit.

Learning lessons when things go wrong
● We found multiple occasions when the provider had not identified shortfalls in wound care and medicine errors in a timely manner. In addition, the provider had not shared learning with staff to reduce the risk of further harm or errors occurring. For example, the provider identified a medicines error but during our inspection visit five days later, we found the provider had not identified two previous occasions when this had happened. Furthermore, the provider had not shared learning with staff and we found the error had been made again that day.

The provider had failed to manage medicines safely and robustly assess the risks relating to people's health, safety, and welfare. This may have caused harm to people and did not reduce the risks associated with medicines. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Environmental safety checks were carried out. The provider was taking action to address any issues identified. For example, fire safety improvements were ongoing.

Systems and processes to safeguard people from the risk of abuse
● People were not adequately protected from the risk of harm.
● Staff had not referred all potential safeguarding events to the local authority in line with the local authority's protocols. For example, we found the provider failed to report that people had not received their prescribed medicines and had developed pressure damage to their skin.
● Whilst staff confirmed they had received safeguarding training, described how to identify potential safeguarding concerns, and described the processes they should follow to help safeguard people from harm, we found these were not always followed. For example, a staff member described a person throwing a drink over another person, and several instances of people becoming disorientated and entering other people's bedrooms during the night. None of these potential safeguarding issues had been escalated using the provider's systems or to external agencies. During the course of this inspection we raised eight

safeguarding referrals to the local authority.

The provider had failed to establish systems to ensure people were effectively safeguarded from abuse. 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.

Staffing and recruitment
● The provider assessed people's needs to identify how many staff were needed in the home. However, we found the assessment did not accurately reflect the number or needs of people receiving care. In addition, although the assessment made recommendations, including to increase staffing hours, these were not actioned until a week later and only after we raised this.
● The provider relied on agency staff because they had been unable to recruit and retain permanent nurses. This meant people did not receive consistent care from nurses who had good understanding of their needs and preferences. In addition, the clinical lead role had been vacant since November 2021, resulting in a lack of oversight of clinical issues and delays in people's care and treatment. We raised this with the provider several times during the course of our inspection and resulted in permanent nursing staff being seconded to the service to oversee agency staff.
● People and relatives told us there were not enough staff. One person said, "I have waited for one and a half hours for someone to come and help me get up. They didn't tell me that I had to wait. I do get riled up when that happens." A relative told us, "I have been here for an hour and a half in the past and not seen any staff at all. I have pressed the buzzer and waited 15 minutes for a response." They told us they had heard other people calling out for help and felt staff took a long time to respond.
● Some staff told us there were not enough staff to meet people's needs effectively. One staff member told us, "[Because of the lack of care staff], you worry you are not doing everything as you should be." Another staff member said, "We feel very rushed. You can't [provide care] as well as you want to do it. We physically can't do everything. especially at the weekend."
● There was no reliable record of the staff who had worked in the home. We therefore could not be confident of who provided care or was present in the home on any given date.

The provider had not established systems to ensure suitable numbers of staff were deployed to support people who lived at the service. 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.

● The provider followed safe recruitment processes to ensure staff were of good character.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 somewhat assured that the provider was using PPE effectively and safely. We saw five staff wearing masks that did not cover their noses.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was a strong malodour in one area of the building. The provider had ordered replacement carpet for this area. Staff did not follow guidance to keep closed the bedroom door of a person with an infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. The staff at the service carried out checks before the inspection team were allowed to enter the premises.

Inadequate

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 requires improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People did not always receive effective care and treatment. This exposed them to serious risk of harm.
- People were at risk of poor health outcomes because staff did not always make referrals to external health care professionals in a timely manner. For example, for one person, a referral was not made to a tissue viability specialist until a week after their pressure sore was identified, and no referral had been made for specialist podiatry for a person who required this.
- Where referrals had been made, these did not always contain accurate information to enable the healthcare professional to make appropriate assessments. For example, staff informed a health care professional the day before our first inspection visit that they had referred a person to a dietician. However, we found this referral had not been made.
- Staff had not always followed specialist healthcare professional's advice. For example, in relation to wound care management. This resulted in delays to a person receiving appropriate treatment, placing them at risk of further poor health outcomes.
- People's needs were assessed prior to the start of their care. However, assessments and care plans were not always updated to reflect people's changing needs or preferences. Care plans did not always include sufficient or personalised information for staff to follow so that they could meet people's needs safely and effectively.
- Care records did not provide assurances that staff were always delivering care in line with people's assessed needs.

The provider had not ensured people's care and treatment was appropriate and met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 Regulations 2014.

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

- People's fluid and food intake was inconsistently managed. Staff had not completed appropriate reviews of people's nutritional needs, and people's fluid intake charts did not always guide staff as to each person's target daily fluid intake. This meant staff may not know whether a person had received sufficient fluids each day.
- People's fluid intake was not always monitored and actions were not recorded to encourage and support people to increase their fluid intake. Despite the provider's assurances, we continued to find these records were not satisfactorily completed and we therefore could not be confident people were receiving sufficient

fluids.
● Records showed people's weight was not always monitored in line with their risk assessments. For example, a person who should have been weighed weekly was weighed only five times in 11 weeks. This put people at further risk of weight loss not being appropriately managed.
● We saw drinks were not always in people's reach. For example, for people in bed who were able to drink independently, we saw cups placed out of reach on bedside tables or across the room.

The provider had not established systems to ensure people were consistently supported to receive adequate diet and fluids in line with their nutrition and hydration needs. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they liked the food and were given choice at mealtimes. One person told us, "The food is lovely, and you get a choice. You can always get something that you like."
● Staff provided people with assistance when this was needed.

Staff support: induction, training, skills and experience
● Staff received an induction when they were first employed at the service. However, they did not always receive an induction when they were promoted into new roles within the senior team. The lack of induction meant staff did not always know and understand the provider's systems or their responsibilities. For example, we found the registered manager was not familiar with the provider's reporting systems and were unable to find key audits, such as care plan audits. One staff member told us, "I've not had much of an induction [in my current role]. I don't feel I've had enough training or induction without a doubt."
● Not all staff had completed relevant training within the provider's expected timeframe. The registered manager was addressing this and had written to staff with short timescales for completion. An area quality director told us that good progress had been made and for example, all staff had completed safeguarding and healthy skin training by the end of our inspection.
● The provider had not followed their own policy and ensured staff received regular supervision. The registered manager told us that "around 47%" of staff had received supervision. Records showed nine staff were overdue in receiving supervision and six staff had not received any supervision in over six months. This meant service users were receiving care from staff who you had not supported to develop or improve their practice.
● Staff felt well supported by their colleagues, but some staff did not feel managers were supportive. One staff member told us, "We don't feel staff are appreciated, we feel moaned at."

Adapting service, design, decoration to meet people's needs
● The environment did not support people who were living with dementia to orientate themselves within the service. For example, there was not adequate signage for people to access toilets independently or to identify their bedrooms.
● The provider had identified that some carpets were damaged and had ordered replacements.
● People told us they liked the service. One person said, "It is better now it has been decorated. We had a say in the colours that they used. It looks much brighter now."

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider had systems in place to assess, review and report on people's mental capacity and decision-making abilities.
- Some people had mental capacity assessments in place and decisions were made in line with principles of the MCA and in people's best interests. However, the provider did not always ensure people's mental capacity and ability to make decisions was routinely reviewed or when their physical and mental health deteriorated.
- Staff had received training in the MCA. However, they could not all tell us who had a DoLS authorisation in place.
- People told us staff sought their permission before providing personal care. One person said, "[Staff] always talk to me about what they need to do, it is fine."

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to Inadequate. 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; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence;

- Staff did not always respond when people sought their attention. One person called out to staff several times during the first day of our inspection, saying they had "a pain." We saw when staff did acknowledge the person, they became calm. However, some staff ignored the person and carried on with what they were doing. Another person became frustrated by the person calling out and told them to "shut up."
- The provider failed to take effective action to ensure people's personal space was respected. Three people told us other people entered their bedrooms during the night uninvited. One person said, "I have had another [person] wander into my room. [They] can be abusive." The person told us staff were aware and removed the person from their bedroom but said the person "Still does it." One staff member told us a person went into other people's bedrooms, "All the time." And other people, "Don't like it." Staff told us they tried to "distract" the person, but this was clearly not effective.
- Staff did not always treat people's possessions with respect. Relatives told us that their family member's clothes went missing. One relative told us, "I have had to hunt for things when they go missing and then other people's nightwear and underwear are in my [family member's] drawers." A relative told us staff used their family member's personal possessions to wedge open a window. They said, "It's my [family member's], they have no right to do that."
- Not all staff respected people's privacy, dignity or confidentiality. We twice heard a staff member tell a person they needed to check the person's blood sugar levels and proceeded to carry out the test at the dining room table in front of other people. We also heard several instances when staff spoke about people within earshot of other people living at the service.
- Not all staff always involved people in decisions about their care or supported them to be as independent and receive care in a dignified way. For example, we saw a staff member standing beside a person who was sitting at a dining table. The staff member held a beaker to the person's mouth for them to take a drink. When they removed the beaker, the person coughed, and the staff member rubbed the person's chest. The staff member did not say anything to the person during this time. This person was able to drink independently when supplied with a straw.

The provider had not ensured people were treated with dignity and respect or their independence promoted. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us that some staff always closed the door and curtains before providing personal care'
● Some people told us they made decisions about their day to day lives. However, there were inconsistencies in the way some staff offered people choices in ways that supported them to make decisions. One person said, "I please myself and go to bed when I want. [Staff] don't force you to do things."
● Some people told us they had been offered a choice of gender of the staff providing their care. One person said, "I only have a female [staff member] help me with personal things. I wouldn't have a male [staff member] and they agree to that."
● Staff offered people choices in ways that supported them to make decisions. For example, in addition to the menus, staff showed people a small plate of each meal choice to choose from.
● People told us they liked the staff. One person said, "The staff are good, kind people. They have helped me a lot." Another person told us, "The staff talk to people nicely. I am surprised they are as patient as they are."

Inadequate

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 requires improvement. At this inspection the rating has changed 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; End of life care and support; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not receive person-centred or responsive care. Agency workers and senior managers new to the service had limited understanding about the people's needs and preferences. This meant people's needs and preferences were often not met. For example, we found significant shortfalls in relation to wound care. Key information was not shared effectively across the staff team. For example, during a staff meeting a nurse told staff a named person had had a fall the previous day. When we requested further information, we found it was a different person who had fallen.
- People's care plans and risk assessments contained conflicting information and were not always up to date and reflective of their current needs. For example, three people's health deteriorated during our inspection. However, their changing care needs were not reflected in their care plans. This meant staff may not be aware of their needs and may not provide effective care.
- A person's care plan was not updated to reflect they would not have any further investigations into a health condition, until we raised this with managers for a third time. This meant, staff may not have been aware of this decision and, should the person's health deteriorated again, they may have experienced an unnecessary hospital admission. Another person's profile information advised they had a catheter. However, the registered manager told us this was no longer the case. This meant staff did not have access to correct information to provide safe and effective care.
- Each person had been allocated a key worker. However, not everybody knew who their key worker was or had been introduced to them. A relative showed us a that their family member's keyworker was identified on their wardrobe door. However, the relative, who visited regularly, said they had never met this staff member or been introduced to them.
- People were not supported to make informed decisions about their end of life care in a person-centred or timely way. We identified that a person who was receiving end of life care, did not have an end of life care plan in place. We raised this on three separate inspection visits before this was put in place.
- Some staff told us they did not have time to read people's care plans and relied on information handed over from other staff.
- Some time was allocated for activities staff to spend with people who were unable to leave their bedrooms. However, relatives told us they felt their family members were isolated and did not have much contact with staff outside of when they received personal care. One relative said, "There is very little time for staff to spend with [my family member]."

The provider had not ensured people's care and treatment was person-centred. People's care plans were

not personalised and did not reflect their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was in the process of introducing care plan summary sheets to provide "at a glance" guidance for staff about people's needs. They told us this would help ensure people received continuity of care.
● People told us staff had involved them in care planning. One person said, "We had an initial chat and they asked for your likes and dislikes. They seem to take notice of what you want and need." Another person told us, "I have talked to the staff about my care plan. I can't remember when."
● People who were able to access communal areas told us they had opportunities to pursue interests and join in communal activities. One person said, "We do quite a bit. I spend a lot of time in the garden. We go out on trips, have a drive around. We play dominoes." Another person said, "I am not into activities, but I do like to play dominoes and watch the TV. If you want to do things, then they have things happening most of the time." Organised activities were advertised. These included a gardening club, men's pampering sessions, and quiz afternoons.
● Staff supported people to maintain contact with people who were important to them. One person told us, "Visitors can come when they want, and I can speak to my [relatives] on the phone when I want."

Improving care quality in response to complaints or concerns
● A relative told us they felt their concerns had not been listened to or addressed. They gave us examples of when they spoke with the registered manager about staff not spending enough time with their family member but felt nothing had changed.
● The provider had a complaints procedure. The registered manager kept a record of complaints. However, they had not documented all the concerns received.
● People told us they felt confident raising concerns and complaints. One person said us, "I would just speak to one of the senior people, but I haven't had to complain about anything."
● People told us their complaints were listened to and actioned. One person said, "I complained about a member of staff, I haven't seen [them] since."

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.
● Documentation was available in alternative formats if required.
● Care plans contained information about people's communication needs, such as whether they needed any aids to help them communicate.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Continuous learning and improving care; Working in partnership with others

At our last inspection the provider's systems to monitor and improve the quality of the service were not fully effective, which meant people were at risk of receiving a poor service. This was a breach of regulation 17 (1) (a) (b) (c) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Since our last inspection the provider had failed to establish effective governance systems to monitor and improve the service. During the course of our inspection we found serious shortfalls in relation to pressure care and wound management, medicines management, and the monitoring of people's healthcare conditions. There were failures to report incidents of concern within the provider's organisation, and externally to local authority safeguarding teams. Systems and processes, including those to identify risk, and ensure sufficient staffing and staff supervision, were not robust, and oversight was not effective. There was an absence of managerial and clinical leadership and guidance to ensure people's health and care needs were assessed, reviewed and met.
● The provider had failed to learn when things went wrong. During the course of this inspection we raised numerous concerns with the provider. They responded quickly and described the improvements they had put in place and further actions they planned to take to improve the quality of the service and ensure safe and effective care was provided. Despite this, we found the provider did not effectively implement their action plans, failed to share their action plans with senior managerial staff, and failed to sufficiently monitor that improvements were being made or sustained.
● Throughout the inspection there had been a lack of continuity in senior management overseeing the service and implementing the provider's action plan. They received a limited handover of information which resulted in actions not being carried forward and outcomes for people not improving.
● We could not always rely on the accuracy of the information the provider gave us. For example, the provider told us no-one in the home had fallen on a specific date, however, we found this was not the case and one person had fallen on that date.

● Staff promoted within the service had not always received an induction resulting in them not being familiar with the provider's systems and failing to report events to the provider and the local authority.
● There was a lack of quality monitoring at the service, a continual lack of improvement, and a lack of understanding about effective governance to ensure people were being supported in line with current legislation and guidance at the service. This meant people were at risk of care and support not meeting their needs. We could not be assured the provider would make or sustain improvements.
● Records were not consistently accurate, up to date, legible, or available. These included people's care records, staff handover sheets, rotas, and records of who was in the service at any time.
● The provider had not worked in partnership and effectively communicated with external organisations. For example, they had failed to make referrals to the local authority safeguarding team and external healthcare professionals. This put people at risk of harm and poor care.

The provider had not ensured systems to monitor and improve the quality of the service were effective which meant people were receiving a poor service. The provider had failed to ensure records were accurate, up to date, legible, or available. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There had not been a positive culture to encourage staff to attend meetings, but this improved during our inspection. Some staff told us they had stopped attending staff meetings prior to our inspection. One staff member told us, "I feel [staff meetings] are a dig or a moan." Further staff meetings took place during our inspection and staff told us they felt more supported by these.
● People and their relatives confirmed they were asked for their views about the service through surveys. The registered manager told us these waiting for responses at the time of our inspection.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's care and treatment was person centred, appropriate and met their individual needs. People's care plans were not personalised and did not reflect their needs and preferences. Regulation 9 (Person-centred care)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were treated with dignity and respect or their independence promoted. Regulation 10 (Dignity and respect)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not established systems to ensure people were consistently supported to receive adequate diet and fluids in line with their nutrition and hydration needs. Regulation 14 (Meeting nutritional and hydration needs)

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 The provider had not established systems to ensure suitable numbers of staff were deployed

to support people who lived at the service. This placed people at risk of harm.
Regulation 18 (Staffing)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to manage medicines safely and robustly assess the risks relating to people's health, safety, and welfare. This may have caused harm to people and did not reduce the risks associated with medicines. Regulation 12 (Safe care and treatment)

The enforcement action we took:

We issued a notice of proposal to remove the location from the provider's registration and cancel the manager's registration.

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 The provider had failed to establish systems to ensure people were effectively safeguarded from abuse. This placed people at risk of harm. regulation 13 (Safeguarding service users from abuse and improper treatment)

The enforcement action we took:

We issued a notice of proposal to remove the location from the provider's registration and cancel the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems to monitor and improve the quality of the service were effective which meant people were at risk of receiving a poor service. The provider had failed to ensure records were accurate, up to date, legible, or available. Regulation 17 (Good governance)

The enforcement action we took:

We issued a notice of proposal to remove the location from the provider's registration and cancel the manager's registration.