Aveland Court Care Limited

Aveland Court Care Home

Inspection report

Aveland Road
Babbacombe
Torquay
Devon
TQ1 3PT

Tel: 01803326259
Website: www.avelandcourtcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Aveland Court is a residential care home providing personal care to 21 people aged 65 and over at the time of the inspection. The service can support up to 30 people in one adapted building.

People's experience of using this service and what we found
Since the inspection in August 2019, frequent changes of management led to a lack of leadership, and oversight of the service. This had impacted on the quality of the service provided and resulted in risks to people's safety not being identified and managed effectively. At the time of this inspection the provider had taken steps to strengthen the leadership at the service and had appointed an experienced head of operations. They were also in the process of recruiting a new manager.

Systems and processes to monitor the safety and quality of the service continued to be ineffective. The provider had failed to act following our last inspection and had also not identified the additional concerns we identified during this inspection.

People were not always being safeguarded from the risk of abuse. Staff were not all following the safeguarding process and staff did not always recognise potential safeguarding concerns, as a result these were not appropriately escalated.

People were not always safe and were at risk of harm. We continued to observe staff using unsafe moving and handling techniques. Risks were not always identified, assessed, or include sufficient guidance for staff. People's monitoring charts were not being completed consistently; such as, charts monitoring food and fluid intake and repositioning.

People were not always supported to eat and drink enough to maintain their health and reduce the risk of dehydration and malnutrition.Sufficient risk assessments or management plans were not in place to support staff to effectively manage the risk.

Care plans did not always contain enough information to ensure staff knew how to deliver appropriate person-centred care based on people's needs and preferences. Where information was recorded this was not always accurate, up-to-date and did not provide evidence of staff interventions.

Medicines had not always been managed safely, and we were not assured people received their medicines as needed and as prescribed.

People did not always have access to health care professionals to support them with their care and when healthcare advice had been given, this was not always followed.

Staff were not sufficiently trained to provide effective safe care. Staff had not received all the training and

support they required. Reliable records were not kept of staff training.

There was not always a caring culture at the service, as people were not always supported in a respectful and caring way. Some people told us about interactions and conversations they had with staff that did not demonstrate care, compassion or understanding. However, we did see some caring interactions between staff and people and staff told us they were trying their best.

People were not 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; the policies and systems in the service did not support least restrictive practice.

Accident and incidents were not appropriately managed and there was no system in place to learn from incidents and prevent reoccurrence.

People were not always supported to engage in meaningful activities. For example, people being cared for in bed did not have access to organised activities or one to one activity.

At the time of this inspection the provider had taken steps to strengthen the leadership at the service and had appointed an experienced head of operations and an experienced manager. The service was continuing to be supported by and work with, the local authority safeguarding and quality teams to improve care.

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

Rating at last inspection
The last rating for this service was requires improvement (published 7 September 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to the management of risks to people, medicines management, meeting people's eating and drinking needs, staffing levels, staff training, person-centred care and the governance of the service at this inspection.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. At the last inspection we required the provider to update us on improvements being made. This will continue.

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
We will discuss our findings with the provider to determine how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore '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 six 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 effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well led.

Details are in our well led findings below.

Inadequate

Aveland Court 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
On the first day of the inspection the inspection team consisted of an inspector, a pharmacy inspector and an Expert by Experience. The second day of the inspection was conducted by two inspectors. 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
Aveland Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission at the time of the inspection. The provider was legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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. This information helps support our

inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with thirteen people who used the service about their experience of the care provided, nine relatives and one visiting health professional. We spoke with 11 members of staff. These included the provider, the interim manager, the head of operations, the administration manager, team leader the cook and five care staff. We walked around the home to check it was a clean, safe place to live and also carried out observations. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records. We looked at medicines and records about medicines for 13 people. We looked at three staff files in relation to recruitment and records relating to staff training, supervisions and appraisal. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We contacted staff working at the home and received feedback via email from five staff members. We asked for and reviewed information the interim manager and provider had sent us. This included training and supervision information, policies and documentation relating to staffing.

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.

Systems and processes to safeguard people from the risk of abuse

- People were not always being safeguarded from the risk of abuse.
- Management of potential safeguarding concerns at the service was not robust or effective. For example, safeguarding incidents were not recorded appropriately and there was no evidence that action had been taken or incidents had been reviewed as a way of identifying trends to prevent a recurrence.
- Staff were not all following the safeguarding process in the service and staff did not always recognise potential safeguarding concerns, as a result these were not always escalated. For example, we heard a person making an allegation of abuse during our inspection, but staff did not record or report this. This meant the person was placed at further risk of harm of abuse. We had to intervene and report it to the local safeguarding authority.

Robust practices and procedures had not been implemented to ensure people were protected from potential abuse. This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last inspection in 2019 we found the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had not been made and the provider was still in breach of Regulation 12.

- We saw there had been some improvements to the way medicines were managed since our previous inspection. However, we could not be assured that people always received their medicines in the way prescribed for them.
- We found one or more gaps in seven people's medicines administration (MAR) charts, where it was not possible to tell whether doses had been given as prescribed.
- We found two people where supply problems had meant that regularly prescribed medicines had not been given. This included an anti-epileptic medicine missed for five days, and one person missing three medicines for over two weeks. There was no evidence that any harm had been caused by these omissions.
- One person had been prescribed a medicine labelled for a five-day course, which was recorded as being given for 10 days. The quantity of medicines recorded as being held in the home did not match with the quantities being signed as given, meaning it was not possible to check the administration of this medicine

accurately.
● Where people were given their medicines covertly (without their knowledge or consent) then mental capacity assessments were made and 'best interests' decisions recorded. However, there was no record that it had been checked with the pharmacist about how to give medicines in this way, safely. Staff were unaware of whether an antibiotic capsule could be opened to mix with food or drink. One person had covert medicine paperwork and a best interests decision in their care plan, however this was not held with their MAR chart. A member of staff told us they were not administrating these medicines covertly as they were not aware of the protocol. This meant that doses were being regularly recorded as refused and missed.
● There were systems in place to record the application of topical creams and other external preparations, however records we checked were poorly completed and we could not be assured that these preparations were being applied as prescribed.
● The interim manager told us medicines training had been updated for staff, and competency checks were being completed to check that staff could give medicines safely. Staff told us medicines audits were undertaken. However, at the time of the inspection, only six staff had received training and there was no evidence available of competency checks, or medicines audits undertaken.

Medicines were not being managed in a safe way and people were not protected from potential harm. This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had received support from the local authority medicines optimisation team to try to improve medicines management. The issues we found had been picked up and were being investigated and actions were being taken to address the issues.
● Following the inspection the new manager told us they were working hard to strengthen their medicines management and key staff were being re-trained to ensure safe practice.
● Medicines were stored securely, and arrangements were being made to move medicines to a new storage room, which should help create a quiet space to prepare medicines for administration. Storage temperatures were now being recorded and monitored.
● Protocols were now available for medicines prescribed to be taken 'when required', to guide staff as to when it would be appropriate to give a dose.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At the last inspection in 2019 we found the provider had failed to ensure the risks relating to the health safety and welfare of people were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of Regulation 12.

● Since the last inspection in August 2019 the service was being supported by the local authority in a whole service safeguarding process and received support to make improvements. Prior to this inspection further concerns were reported to us and the local authority relating to the quality of care and safety of people living at the service and improvements made had not been sustained.
● At this inspection it was not clear that lessons had been learnt as the same incidents found during previous inspections, were reoccurring.
● People were not always safe and were at risk of harm. We continued to observe staff using unsafe moving and handling techniques which were not in accordance with good practice guidelines and could place the

person and staff at risk of harm and injury. For example, staff helping people to stand using an underarm lift and using incorrect techniques when assisting people with a stand aid.

● Risks were not always identified or comprehensively assessed. Risk assessments did not always include sufficient guidance for staff. For example, there was no care plan or risk assessment in place for one person living with epilepsy. There was no information or guidance for staff about how a seizure affected the person or what action staff should take, such as recording and monitoring the seizures, or when it might be necessary to ask for additional medical support.

● People's monitoring charts were not being completed consistently; such as, charts monitoring food and fluid intake and repositioning to avoid pressure damage. Where risks had been identified, people relied on staff to ensure these areas of their care were monitored closely and action taken when required. Incomplete records did not ensure staff had sufficient oversight of each person's needs and changing risks.

● Some people were assessed as being at risk of pressure damage to their skin. People's repositioning charts had not always been completed to show that they had been repositioned as they should and as documented in their care plan. For example, one person had developed a pressure sore on their shoulder. There was a skin integrity care plan in place that guided staff to change the person's position, two hourly. There were specific instructions to position the person avoiding their left-hand side, to reduce pressure to this area. Records did not always show that care was being delivered consistently and as written in their care plan. This meant the person was put at increased risk of further pressure damage to their skin.

● Where people had demonstrated 'distressed behaviour', care plans and risk assessments in place did not always contain sufficient guidance. There was no information to guide staff about potential 'triggers' for anxiety and behaviours resulting from anxiety, and there was no evaluation of the behaviour to learn lessons and further support people. This placed people and staff at risk of ongoing harm and meant some people were not having their needs met. For example, the interim manager told us one person had a history of making allegations against staff and there should be two staff providing personal care. We found there was no risk management plan around allegations and this person was supported by one member of staff for personal care on the second day of our inspection.

● Accidents and incidents were recorded in a log. This was not always completed accurately. We found several instances of physical aggression that were not recorded as an incident. This showed a lack of oversight of incidents and poor linking between records regarding risks that people and staff faced. This placed people at risk of potential harm.

● There was a failure to assess any patterns of risks regarding accidents and incidents. Falls were not analysed and incidents of heightened or distressed behaviour were not monitored so they could be explored and reduced. The interim manager confirmed this. This placed people at risk of potential harm.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our visit, we were concerned about the risks to people and wrote to the provider and asked for information about the actions they would take promptly to protect people from harm. The action plan showed commitment to dealing with the issues but relied on one person, the new manager, to manage risks and drive improvement. We voiced our concerns to the provider who told us the new manager would be supported by themselves and the head of operations. The management at the service was further strengthened at the service by the employment of two deputy managers to ensure constant leadership and oversight.

● Despite our findings, people told us they felt safe living in the service.

● Equipment such as fire detection systems, hoists and water quality were regularly tested for safety.

Staffing and recruitment

● Prior to the inspection we received concerns from a whistle blower that there were insufficient staff to meet the needs. During this inspection we found there was not always sufficient staff on duty.

● Some people told us they often had to wait for long periods of time for their needs to be met. One person became visibly distressed when they told us about their experience, "I kept ringing the bell this morning and, in the end, I wet myself. After a while they came. It's my fault."

● A visiting health professional told us, "Last Thursday or Friday I visited, there appeared to be only two members of staff on, they weren't very helpful, and it seems rather hectic."

● Staff told us they needed more staff in order to meet people's needs. One said, "You can see for yourself we don't have enough staff." Other staff members told us when they were short staffed people had to wait for care.

● We spoke with the interim manager about staffing levels. They told us core staffing levels Monday to Friday, were five care staff during the day and three at night, reducing to four staff during the day at weekends. They told us they would never allow staffing to go below four staff on duty during the day.

● We looked at the staff rota from 10 February to 1 March 2020 and found six day shifts and sixteen-night shifts where there were less than the minimal staffing levels allocated on duty.

● The way staff were deployed also meant that people's needs were not always met and they were not always kept safe. There was a lack of staff presence in the lounge for long periods whilst the staff were busy assisting others.

The provider failed to ensure there was enough effectively deployed staff to meet people's needs in a timely way. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The interim manager and provider told us there had been a recent recruitment drive which included the employment of senior staff. They told us this would increase and strengthen the staff team and decrease the numbers of agency staff being used. Agency staff used were familiar to the service and had undergone an induction.

At the last inspection in August 2019 we found the provider had failed to ensure staff were recruited safely. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of Regulation 19.

● Recruitment procedures ensured the necessary checks were made before new staff commenced employment. Checks made included references for new staff, for example from previous employers in care, and disclosure and barring service checks (DBS) were carried out to ensure new staff were safe working with vulnerable people.

Preventing and controlling infection

● Improvements had been made and were underway following a recent infection control site visit by the local authority.

● During the inspection we noticed a number of rooms, including people's bedrooms, had staining on the ceilings from water leaks and in some rooms, mould was growing. We spoke with the provider about this who told us this has been looked at by the maintenance staff and there were plans in place to make the necessary repairs.

● We observed staff used Protective Personal Equipment (PPE) such as aprons and gloves when needed. There were adequate hand-washing facilities available throughout the home.

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 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.

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

● Although some people spoke favourably about the food, we found staff did not always support people to eat and drink enough to maintain their health and reduce the risk of dehydration and malnutrition.

● People at risk of becoming malnourished or dehydrated did not always have sufficient risk assessments or management plans in place to support them to effectively manage this risk and ensure people's nutritional needs were met.

● Food and fluid recording and monitoring was haphazard. Charts were not completed consistently and did not show exactly what people had consumed throughout the day or the amounts. This meant staff could not be sure people were getting sufficient to eat and drink. For example, we looked at one person's fluid recording records over a period of 30 days. We found on 14 days care records did not contain a fluid recording chart documenting the person's fluid intake. Of the remaining days when fluid recording records had been made, we found staff were often recording intake on multiple charts. Records showed on five days, fluid offered to the person per day was below 500mls. A similar pattern was noted in a further three files reviewed.

● This person had also been refusing food and drink as it was causing them pain. The person had lost 27kgs between February 2019 and February 2020 and we saw the person had a dry mouth and dry skin, indicative of dehydration. The person had been seen by their GP who prescribed medicines to alleviate discomfort and advised staff to contact the surgery if they continued to not eat and drink. Despite the person continuing not to eat and drink sufficiently to maintain their health, records showed staff had not contacted the GP for a review nor did they contact a dietician for help and advice. There was no strategy in place to address their nutritional needs. The person's care plan simply advised staff to offer the person an attractively presented 'finger food/grazing diet'. We saw no evidence from food charts, or from our observations during the inspection, that this was happening, and we did not observe staff sitting with the person prompting or encouraging them to eat.

● There was a failure to identify where one person was not receiving the support with nutrition and hydration that they needed. This person was being placed at an ongoing risk of harm. We had to intervene to ensure the safety of this person and reported the concern to the local safeguarding authority. A community dietician visited the service to make an assessment of their needs and put robust plans in place.

● People's specific dietary preferences related to their moral or ethical beliefs were not always being fully considered or met. For example, one person was a vegetarian. We saw from their food charts that on more than one occasion they had been given the meat option for their meal.

● We saw staff helping some people with their meals and encouraging others. However, we also observed a staff member feeding one person their meal. The staff member did not speak to the person, check if they

were enjoying their food or give encouragement.

The service did not have an effective system in place to ensure people received adequate nutrition and hydration that met their preferences. This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection in August 2019 we found the provider had failed to staff were suitably qualified, skilled and competent to meet people's needs effectively. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of Regulation 18.

● The provider failed to ensure staff received appropriate training, supervision and appraisals to ensure staff were suitably skilled and experienced for their role. Reliable records were not kept of staff training.
● The training matrix showed that staff were not sufficiently trained to provide effective care. For example, only 28% of staff had completed training in manual handling, 32% in health and safety and 36% in safeguarding adults. The failure to provide effective training had impacted on staff providing safe and person-centred care.
● Since the last inspection in August 2019, there was no evidence to show staff competency had been checked to make sure they supported people effectively.
● Supervisions and training records did not evidence a robust approach to monitoring and supporting staff wellbeing and continued development.

The provider had failed to ensure all staff had received appropriate support, training, and supervision as is necessary to enable them to carry out safe effective care. This was a continued breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 we found the provider had failed to work within the principles of the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider continued to be in breach

of regulation 11.

● At the last inspection we found Mental Capacity assessments and best interests decisions had not been completed for all decisions made in relation to people's care. At this inspection we found this continued to be the case. For example, a mental capacity assessment and best interests decision was not recorded for one person who had a crash mat in place to stop them from injuring themselves if they rolled out of bed.
● Best interests decisions were not recorded for key decisions such as whether a person should or should not be referred for hospital investigations when they had been deemed as lacking capacity to decide for themselves.
● There was no system in place for reviewing decisions that had already been made. For example, records showed some capacity and best interests decisions had been recorded from 2018. There was no evidence these decisions had been updated or reviewed to ensure they continued to be the least restrictive and appropriate option and were meeting the principles of the MCA.
● Where applications for DoLS had been made or authorised the service had not kept them under a review to ensure decisions were being met in line with the conditions.
● Staff had not received training to help them understand the Mental Capacity Act 2005. Only seven out of twenty-five staff members had received training in MCA.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People did not always have access to health care professionals to support them with their care. For example, the service did not always ensure people were registered with and seen by a dentist in order to help identify any prevent oral health problems.
● People's oral health care plans were not always sufficiently detailed to ensure staff could meet their needs. Records did not demonstrate that people who needed support with their oral health, received the support they needed. We concluded oral care and treatment was not appropriate and did not meet people's needs.
● The district nursing team supported staff for all medical interventions, such as, wound dressings and catheter care. However, we saw that when healthcare advice had been given, this was not always followed. For example, caring for a person's skin by repositioning them regularly and in a way that protects their skin.

This is a breach of Regulation 12 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
● Since the last inspection the service had not taken any new admissions.
● We found concerns throughout this inspection that reflected care was not always being provided in line with standards, guidance and regulations.
● Assessments and records did not always include sufficient guidance for staff about how to support people. For example, to maintain a balanced diet and to drink enough or how staff should protect people's skin.

Adapting service, design, decoration to meet people's needs
● Since the last inspection the environment had been improved in places, including some bedrooms re-decorated, and the dining space and lounge areas re-defined. However, there were still areas in the home which looked tired and worn.

● Improvements had been made to adapt the environment for people living with dementia, including signage on some doors and in corridors and an activity and menu board in the hallway.
● Some bedrooms had been personalised and were individual to the person. Some people had brought their personal belongings which had been used to make their rooms familiar and comfortable. People had access to an outside garden area.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always well-supported, cared for or treated with dignity and respect as their individual needs were not always met. The lack of prompt and effective action to identify and address concerns highlighted during previous inspections did not support the dignity of the people living in the service.
- There was not always a caring culture at the service, as people were not always supported in a respectful and caring way. Some people told us about interactions and conversations they had with staff that did not demonstrate care, compassion or understanding. For example, one person told us about a conversation they had with staff about their eating and drinking, "I was told to pull myself together, the staff just don't understand, I can't eat. I was told I couldn't be choking because I was able to talk." Another person told us, "Some of them (staff) are excellent, but a few are not very nice, they are sometimes impatient. A member of staff did say 'bugger off' to me, 'that it was not worth it', I can't remember properly." The person became tearful and upset when they told us about this.
- Care records did not always refer to people in a respectful way. For example, one person's records described the person as demanding and very demanding.
- People's choice of the gender of staff supporting them with personal care was not always respected. One person had requested to receive personal care from female members of staff only. During the inspection we observed they received personal care from a male member of staff.
- People could not always call for assistance when they needed. Some people did not have call bells to hand in their bedrooms and there were no call bells within people's reach in the lounge. One person sat in the lounge, became distressed as they had been calling out for staff to help them to the toilet for some time. When no staff came to their aid, we intervened and found a staff member who took them to the toilet.
- People's private information was not always kept securely and risked breaching confidentiality. For example, one person's 'protocol' for managing their seizures was displayed on the wall in their room.

The provider failed to ensure people were treated with dignity and respect. This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the concerns identified during the inspection, staff we spoke with were very motivated and caring and we observed kind interactions. Staff had worked additional hours when needed to ensure consistent care for people.
- Some people told us they were happy with the care and staff were kind and caring. One person told us, "They [staff] treat me as a friend. I can't speak highly enough of them, they're really, really nice. I have never

heard anyone be rude to anyone." A relative told us, "What I have seen, people seem well cared for. The staff are friendly and helpful and the place smells clean. My mother seems happy enough. They seem to treat everybody with respect."

● Care plans included basic information about people's cultural preferences, values and beliefs, and any religious and spiritual needs. Only two staff members had received equality and diversity training.

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

● People said they were not aware of any regular meetings to discuss their views or knew about their care plans. Care plans did not clearly identify if people had consented or were involved in making decisions related to their care.

● Whilst we observed staff giving people choices about what they wanted to do and where they spent their time. Some people told us they were not always supported to make their own choices regarding their daily routines. For example, when we asked one person whether there were set times to get up and go to bed they, told us, "They are quite strict about bedtime." Another person said, "We go to bed early because there is so many of us here."

● Residents meetings were not held regularly to give people an opportunity to raise concerns or offer suggestions as to how their experiences could be improved.

People did not receive person centred care and treatment that was appropriate to meet their needs and reflect their personal preferences. This was a breach of Regulation 9 Person-centred care of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

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 remained the same. This meant people's needs were not always met.

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

● Care was not always planned in a personalised way to ensure people had choice and control and to meet their needs and preferences. The standard of care plans presented a risk that people might not receive the care they needed.

● Some care plans were not detailed, accurate, up-to-date or reflective of people's current care needs. For example, one person's care plan referred to "regular repositioning" to reduce the risk of developing pressure sores but did not specify how often the person required this. The lack of detailed and accurate information placed people at potential risk of receiving care that did not meet their needs.

● Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care. Care plan did not always contain
information about people's life history and interests and had little information about their likes, dislikes or preferences.

● Where people could be anxious or distressed and exhibit behaviours that could challenge others, information relating to known triggers and specific guidance for staff on how best to support individuals was not recorded.

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

At our last inspection we recommended the provider sought guidance on activities for people who may be at risk of social isolation. At this inspection, we found the provider had not made the recommended improvements.

● People were not always supported to engage in meaningful activities. For example, people being cared for in bed did not have access to organised activities or one to one activity. One person told us they, "Sometimes had things to do." A staff member told us, "We talk to the residents in-between care. There are no one to one activities in residents' rooms."

● Care plans did not always evidence what activities or pastimes people enjoyed, found meaningful or the support they needed to pursue hobbies and interests.

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 care plans contained basic information about people's communication needs. However, information was not always made available to people in a format they could understand. For example, the activity programme and menu were not in an easy read or large print format to enable people with a disability, living with dementia or sensory loss to understand the information.

End of life care and support
● End of life care plans were not always in place for people. For example, we were told one person was receiving end of life care. Their end of life care plan had not been completed and there was no information about this person's end of life wishes or preferences. Without this information, staff would be unable to ensure people's wishes at the end of their life were respected.
● Training records showed that only three staff had received training in end of life care.

The provider and registered manager failed to ensure people's care was planned in a person-centred way to meet their needs. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had introduced a new electronic care planning system and the interim manager told us since the last inspection the service had been working with the local authority on improving people's care plans. The interim manager admitted this was very much in it's infancy and acknowledged that not enough improvement had been made.
● Following the inspection the interim manager acknowledged shortfalls in care planning, advising us that care plans would be rewritten and there would be robust monthly monitoring of care plans to ensure these reflected people's current needs.
● People had access to organised activities in the main lounge, such as, musical activities, singers, arts and crafts, games and pamper sessions. During the inspection we saw people taking part in a musical activity and singing. Staff told us that when they had time they would engage people in activities.
● People had access to books and games and the provider had bought interactive cats to provide comfort to people.

Improving care quality in response to complaints or concerns
● There was a complaints policy in place.
● The interim manager told us they had received one complaint. We reviewed the complaint and found the interim manager had taken steps to ensure the complainant was satisfied with the response to their complaint in line with the provider's policy.
● Though this was positive, there was a lack of evidence to demonstrate lessons learned and learning outcomes to make the required improvements.

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 inadequate. At this inspection this key question has remained the same. 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 our last inspection the provider had failed to ensure systems and processes were established and operated effectively to meet the regulations. Records were not available or complete. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 17.

- The service did not have a registered manager in post. The previous manager resigned following the last inspection in August 2019. During this inspection a new experienced manager was appointed to start with immediate effect.
- Although interim managers had been appointed by the provider to manage the service in the absence of a registered manager, the lack of continuous provider oversight and leadership had resulted in an increase in whistle blowing and safeguarding concerns not being identified and addressed in a timely way.
- The provider and staff had worked in cooperation with the local authority safeguarding and commissioning teams. However, this had not resulted in the expected improvements in care. Indeed, frequent changes in management team had seen improvements made, but not sustained and the quality of the service provided had deteriorated.
- The provider had taken some actions to address the requirement notices and recommendations resulting from the last inspection. These had not been effective. In addition, CQC had imposed a positive condition on the providers registration following the last inspection. This meant the provider had to carry out audits and provide information to CQC. They had complied with this condition, however, it had not resulted in the service improving.
- Quality checking processes and audits were either not completed or ineffective across all areas of care. This meant people were at risk of receiving poor care because the risks to their safety and wellbeing were not mitigated or managed effectively to protect them from harm.
- Records were not always accurate and had not always been updated to reflect changes in people's needs. Care files were disorganised, and information was not always readily available to view.
- People could not be assured of safe care and treatment as this was not being effectively monitored. There was a lack of monitoring and oversight of daily care records to ensure people's needs were met. For

example, in relation to people's food and fluid intake and skin integrity. Where risks to people had been highlighted, it was not clear from records that staff were following the systems in place to reduce this risk.
● Opportunities to learn from incidents, address poor performance and improve practice had been missed. A lack of robust auditing and managerial oversight meant the service did not pick up on concerns when they occurred, meaning they could not learn from them or improve care for people.
● There was a lack of understanding of best practice guidance, and oversight of risks to people to ensure safe care and treatment. Staff had not received the appropriate training or competency checks on their practice to ensure they were able to provide care to meet specific needs.
● Whilst staffing levels were being assessed this was not effective as staff rotas showed staffing levels often fell below the minimum numbers required to ensure safe care that met people's needs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The lack of effective leadership and some staff's attitude, did not promote a positive and person-centred culture in the home.
● People were not always treated with respect, as detailed in the 'Caring' section of this report.

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 interim manager and provider understood the duty of candour and their responsibility to be open and honest when something went wrong. However, their lack of oversight meant they weren't aware of when things were going wrong and therefore did not act appropriately to ensure the safety of people.
● Staff told us they knew how to 'whistle-blow' and to raise concerns with the local authority and the Care Quality Commission (CQC). However, we found evidence of poor practice and staff had failed to report this.
● Safeguarding concerns are not dealt with in an open and objective way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Resident meetings did not take place and minimal opportunity was provided for people to have their say on the service.

Systems were either not in place or not robust enough to manage the safety and quality of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from people and relatives on the overall service provision was mixed but the consensus was that staff were doing their best. One person told us, "The home is fine as far as I'm concerned, I have never had any problems yet, the staff are good and helpful."
● People and relatives told us they felt able to approach the management at the service if they had any questions or concerns.
● Staff spoke positively of the interim manager in place, at the time of the inspection, and the support they received. Staff spoke about how committed they were to provide good care and they felt they worked well as a team despite the challenges. One staff member told us, "When I first started, I didn't know what to expect as I knew the home needed improvement. The atmosphere was awful and there were hardly any staff or equipment and I didn't want to stay. However, the last month has been so much better. We have the equipment we need and good staff and better atmosphere for the residents." Another staff member said, "It hasn't been easy, but we've pulled through together as a team. The staff are amazing."
● The previous performance rating was displayed in the service's entrance hallway making it available to all

visitors and people.

Working in partnership with others

●The service had been working with representatives from the local authority safeguarding and quality team following concerns identified to make the improvements needed. However, with the frequent changes in leadership, improvements made had not been sustained.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager failed to ensure people's care was planned in a person-centred way to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to work within the principles of the Mental Capacity Act 2005. Mental Capacity assessments and best interests decisions had not been completed for all decisions made in relation to people's care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the risks relating to the health safety and welfare of people were managed safely.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Robust practices and procedures had not been implemented to ensure people were protected from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service did not have an effective system in place to ensure people received adequate nutrition and hydration that met their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or not robust enough to manage the safety and quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure all staff had received appropriate support, training, and supervision as is necessary to enable them to carry out safe effective care. The provider failed to ensure there was enough effectively deployed staff to meet people's needs in a timely way.