HC-One Oval Limited

St Christopher's Care Home

Inspection report

Drakes Way
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

About the service: St Christopher's Care Home is a large nursing and residential care home that accommodates up to 163 older people, some of whom live with dementia, in five adapted buildings. There were 135 people using the service at the time of this inspection.

People's experience of using this service:

• Since our last inspection the service has not made the required improvements.
• The provider had systems in place to keep people safe, provide good quality care and ensure staff were trained. These systems had identified concerns within the home. However, not all the shortfalls had been addressed at the time of inspection and there had been a failure to learn from lessons and drive improvement.
• The service met the characteristics for a rating of "Inadequate" in two key questions and the rating of "requires improvement" in three key questions. This gives the service an overall rating of "inadequate".
• People gave mixed views about if their needs were met at the service but they liked the staff.
People told us that they liked the food. However, ways in which the staff could support people in a more timely way needed to be considered.
• People were given choices in some instances but this was not applied consistently across all elements of

their care. For example, times to get up and the use of bedrails.
• People who spent their time in their rooms had limited interaction and social opportunities.
• People told us they needed more to do and more opportunities for activities.
• People were not always supported by enough staff.
• Staff did not always deliver care that was safe and met people's needs.
• Risks were assessed in some cases but this was not consistent.
• The principles of the Mental Capacity Act 2005 were not always adhered to.

• More information about our inspection findings is in the full report.

Rating at last inspection: At the last inspection the rating for this inspection was requires improvement.

Why we inspected: This inspection was brought forward due to information of risk or concern and the previous rating was requires improvement.

Enforcement: Action we told provider to take can be seen at the end of the full report.

Follow up: We will continue to monitor the service and work with other agencies to ensure the provider is working towards meeting the standards and regulations. A further inspection is planned for the future.

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?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not always well-led

Details are in our Well-Led findings below.

St Christopher's Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of poor moving and handling. This inspection examined those risks relating to moving and handling.

Inspection team:
The inspection team was made up of four inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: St Christopher's Care Home is a large nursing and residential care home that accommodates up to 163 older people, some of whom live with dementia, in five adapted buildings. There were 135 people using the service at the time of this inspection.

St Christopher's Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection visit was carried out on 5 March 2019. The inspection was unannounced.

What we did:
• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and local authorities.
• We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We spoke with the manager, the deputy manager, a senior manager, a member of the HR department, the area director and 15 care workers.
• We spoke with 25 people who used the service and 14 relatives.
• We reviewed 13 people's care records, medicines administration records and other records about the management of the service.

Inadequate

Is the service safe?

Our findings

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

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

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

● The provider had systems to help protect people from the risk of harm or abuse which included raising concerns within the organisation and staff received training about this. Not all staff were confident about how they would report any concerns externally to local safeguarding authorities should the need arise.
● People told us they felt safe. One person said, "I am safe here and well looked after."
● At the last inspection in February 2018 we found that unexplained bruises were not always discussed or reported by senior managers for an investigation to be carried out to establish the possible cause.
● At this inspection we saw staff reported skin tears and bruising found on people. They recorded these on body maps. However, staff did not know if these were raised and discussed with local safeguarding authorities. We saw no actions recorded on body maps to detail what lessons were learned or what measures were implemented to reduce the risk of reoccurrence. The managers log of unexplained injuries stated, 'Monitor skin integrity' for all injuries as an action. There had been no theme identified that may have indicated moving and handing concerns. There had been 15 unexplained injuries and one due to an incident while a person was hoisted during February 2019.
●One relative told us, "I don't understand how [person] injured themselves. They don't get out of bed, the bedrails have bumpers and nobody [staff] can tell me what happened. It`s just not good enough." Many of the bruises and skin tears were on arms and hands. We saw staff walking a person very quickly while holding their arms and hands. The bruises and skin tears on this person corresponded with staff holding arms and hands. We asked the manager to complete an investigation.
● Another relative told us, "[Person's] skin is so fragile, it tears mainly on their arms and lower legs. My relative should have (two staff) for their personal care but often there is only one especially at weekends."
At this inspection we found the provider in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because unexplained bruises and skin tears were not always robustly investigated.

Assessing risk, safety monitoring and management:

● Risks to people`s health, safety and well-being were not always fully assessed and the required measures were not put in place to remove or reduce the risks. Some assessments had not been completed and measures to mitigate risk were not always robust. This related to bedrails and the use of protective bumpers.
A person was identified at medium risk of choking and suggested action from the assessment tool for staff

was to involve the speech and language team (SALT). A family member confirmed that the person was struggling to swallow medicines and we heard them coughing in the morning when they were taking their medicines, however a referral was not made to SALT.

● Risk assessments in place for oxygen management did not consistently cover all the risks involved and did not give staff enough guidance to know how to manage this safely. For example, one risk assessment for the use of oxygen did not have warning for staff to keep Oxygen away from open flames or heat source and no warnings about the use of oily creams or alcohol based hand gels around oxygen. Not all staff had received training in relation to safe management of oxygen. One relative had found the oxygen machine standing on the tube preventing the flow of oxygen and causing the machine to overheat. This has left a kink in the tube which could potentially restrict flow. The tubing had not been replaced at the time of the inspection.

●People who needed the aid of a hoist to be transferred had moving and handling assessments in place, however these were inconsistently completed and did not give sufficient guidance for staff.

● Staff told us there were not enough spare slings for people in respite care so that they had to use other people`s slings to transfer these people. There were slings attached to hoists in communal bathrooms that did not have names or room numbers indicating universal use by staff. This increased the risk of cross infection and also using the wrong size or type of sling for a person.

●Staff had received training in relation to fire safety and fire drills were completed. However, actions from a fire risk assessment in April 2018 had not all been recorded as being completed. This included evacuation and remedial building works. The manager told us outstanding work had been passed to the provider's maintenance team.

● A person's automatic door closer, used to ensure the door closes in the event of a fire, was broken. The person was using a scarf to hold it open as they self-propelled in a wheelchair. They told us at night the staff propped it open with a bin or a cushion. The manager told us that it had broken on 20 February 2019 and they were awaiting a repair. They told us they had told the person not to prop open the door. No risk assessment was in place. Following the inspection, the manager told us it had been repaired. However, given the important function of the door closer and the small task to complete the repair, it should have been repaired in a more timely fashion.

● A person who lived at the service had been supporting people to eat. We were told that they were asked to do this by staff who were busy or short staffed. This was confirmed to us that this was happening. A member of the management team told us, "It's ok, [person] knows which people they can't help as they have thickener in their drinks." We challenged the confidentiality concern in this instance in addition to the risks associated with a person who uses the service helping people to eat in their rooms without staff present. The manager was not aware of this and there was no risk assessment or training for the person in place. Following the inspection, we were informed that this had been stopped from happening in the future.

At this inspection we found the provider in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not always have their needs met in a timely fashion.

Using medicines safely:

● Medicines were managed safely by appropriately trained staff. Staff followed best practice guidelines in regard to storage of people`s medicines as well as requesting and booking medicines in the home. We observed staff administering people`s medicines and this had been done respectfully with patience and giving people information about what medicines they were taking. One staff member said, "Here is your [type of medicine]. Take your time."

● Staff had a daily check sheet which they signed to state they had checked all records were completed correctly. We noted two of these sheets had been signed for the following day and one had been signed for

two days in advance. This showed that the control system was not being used effectively.
●We found that a person was put at risk of being overdosed with pain relief due to instructions not recorded clearly on medicine administration records.
● The staff completed daily counts of medicines. One medicine was found to be short of two doses (four tablets). The count had only identified the error once, however, no action had been taken to investigate this or ensure there were no adverse health effects.

Preventing and controlling infection:

● Most staff had received training in infection control practices and personal protective equipment such as gloves and aprons was provided for them. However, staff were not aware that there had been an outbreak of diarrhoea and vomiting and we were only informed by a person who lived at the service. This meant that staff may have been causing cross infection. Outbreak protocol was not in place.
● The units were clean and tidy. Some odours were present at different times during the day but we saw housekeepers working throughout each unit to clean all areas. One person told us, "The cleaners are good, they are always popping in to make sure things are clean." A relative told us, "They seem to keep the place clean and tidy."

Learning lessons when things go wrong:

● The manager took action following some incidents and learning was shared with staff. The manager told us this was done at regular meetings and senior staff were to cascade the information, and at team meetings which had recently started. We discussed the need for the manager to check with staff that that information from their meetings was being shared with them.
● A record of accidents was provided to the provider who completed analysis to help identify themes, trends and ensure all remedial action had been taken.
● However, learning from lessons was not consistently applied, for example in relation to skin tears and bruising, and the provider's experiences in regards to oxygen risk assessment and fire safety.
At this inspection we found the provider in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because infection control was not always promoted, fire records needed to be completed, medicines records needed to be accurate and risk assessments needed to be followed.

Staffing and recruitment:

● People told us they felt there was not always enough staff were available to meet people`s needs. They told us this was typical of needing assistance to use the toilet. A person said, "Sometimes I have to wait a long time when I ask for the toilet." A relative told us, "They are stretched, but they are very friendly and very helpful, I have no complaints. Staff work very hard."
●The service had a number of staff vacancies that they were recruiting for. There was a high use of agency staff to fill the gaps on shifts. Some shifts were not able to be filled.
●We observed eight people in a unit had not had their call bell at hand. Two call bells were on the floor and six were behind people hooked on the wall. Staff told us out of the eight people five people were able to use the call bell. They also told us two people can use the call bell but won't use it so that they don't cause more work for staff. One staff member said, "[Two people] can use the call bell but they are not doing it, they wait for us to go in." Two people told us that they did not like to bother staff by using the call bell. One person told us, "They tell me not to ring the bell so often – that makes me worry about ringing the bell for anything."

● Staff told us they could not provide personalised care to people because there were not enough staff. Staff told us they were allocated to parts of the home to support people and they started from one end of the corridor and worked their way through their jobs. This meant that people`s preferences of when they wanted to get up were not asked or taken into consideration. One person told us, "Everyone here is in pads because the staff don't come fast enough for people to get to the toilet." We were told by people and staff, and had also received feedback prior to the inspection, that running out of continence pads was a frequent occurrence.

● At the last inspection in February 2018 recruitment processes needed to be made more robust.
●At this inspection recruitment practices needed to be consistently followed to help ensure staff were appropriate for the role. References were not always verified. Background checks with the Disclosure and Barring Service (DBS) were completed before staff were employed by the service.
At this inspection we found the provider in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's needs were not always met in a timely fashion.

Requires Improvement

Is the service effective?

Our findings

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

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that they were not always working in accordance with the MCA.
● Mental capacity assessments were carried out in some cases to establish if people had the ability to make informed decisions. However, where people were stated to have capacity, their choices in relation to some areas had not been listened to. People told us that they had bedrails in place when they did not want them. These people had capacity to make their own decisions and in many cases, the correct process had not been followed.
● Not everyone who needed one had an application for DoLS in place and the manager acknowledged that this was a work in progress. The manager told us that no one living at the home had a current DoLS authorisation, however we saw two that were active on people's care plans. The understanding of DoLS and any conditions attached to these needed further development.
● People told us staff asked for their consent before they delivered any aspects of personal care. For example, asking if they could go in and support someone to get washed and dressed. During the inspection we observed people were offered choices with food and what to wear.

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

● People`s needs were assessed before they moved into the home as well as staff carrying out an assessment on the day they moved in the home. A seven-day care plan had been developed to ensure staff had guidance in place in how to meet people`s needs until a more detailed care plan had been created. However, they were not always fully completed when a person moved from a respite placement to living

permanently in the home.
● Care and support plans were reviewed. However, some plans were not in place for areas needed. People told us that they had not been given a choice between having a male or female staff member support them with personal care.
● People gave us mixed views about the care and support they received. One person said, "They look after me, it's very good, they give me food." Another person told us, "I wake up about 6am and I would love a cup of tea and a biscuit but I don't get it." The relative told us that the person eats about 5pm and then has nothing until breakfast which was often late and often not finished until about 10-10.30am. They said, "… which is too long to go without food and drink."

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

● People told us they enjoyed the food and there was enough choice.
●Food served to people looked appetising and hot. Most people ate their meals in their bedrooms. Staff ensured they were comfortable and sat up appropriately to eat their meals in most cases. However due to the high number of people being in their bedroom staff could not observe them if they were eating or if they needed help after staff left the rooms.
●We saw people losing interest in eating and half of their meals were wasted. This was because by the time staff got to check on people and encourage them to eat the meal was cold and people refused to eat. Breakfast did not finish until 10.30am and lunch was served at 12.30pm giving only a two hour break between meals. In between people had been offered pancakes.
●Food and fluid charts were not completed accurately. There were no targets for people and where staff considered actions had to be taken because people were not drinking sufficient amounts the only action recorded was to encourage more drinks. People`s weight was monitored and if they were losing weight they were referred to their GP or dietician for support. The management team had not identified a possible link between people falling asleep in meals due to delay in support to eat, the time in between meals, incomplete fluid charts and people losing weight as they had not implemented a strategy to address this.
● People's specific dietary needs such as allergies or specific diets such as to manage diabetes were known to staff and catered for.

Staff working with other agencies to provide consistent, effective, timely care:

●People and their relatives gave us mixed views about the skills and abilities of staff identifying people`s changing health needs and seeking appropriate support for them.
●One relative told us that on one occasion there was a delay in staff asking for GP input causing the person to be in discomfort for four days. They told us, "[Person] was clearly in pain and discomfort but a staff member told us they cannot call the doctor for this silly `thing`. It was four days until [person] was seen." The manager contacted us after the inspection stating it was an agency nurse who made this comment and they will investigate the concern. This relative also told us staff often administered a less effective pain relief to their family member because there were not enough staff who could safely administer a more effective pain relief which required two staff being present when this happened. They said, "They give [type of pain relief] because there aren't two available staff to give [type of pain relief]. I constantly need to chase them."
●Other people told us that they received pain relief when they requested it. However, another person told us, "They are in a rush and so sometimes the oxygen isn't reconnected after personal care."

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

● We saw evidence of external health professional involvement in people`s care for physical and mental

health needs. Staff supported people to attend hospital appointments and access health care support. There was a regular GP round and people were referred to appropriate professionals when needed in most cases. We saw that dieticians, opticians and other health care professionals visited people when needed. However, delays had been experienced by people. A person had experienced an unnecessary delay in receiving a chiropodist which had left them uncomfortable and a delay in a referral to SALT had occurred. The theme from feedback received was that staff were often reluctant to deviate from their planned routines.

●One relative told us, "When [person] was really ill they didn't acknowledge [person] was very ill and in the end I had to insist, absolutely insist, that they called the emergency doctor and give antibiotics, I then went and got the antibiotics because they were short of staff."

●One person told us, "They put the catheter in in hospital because I had fluid on my stomach but that was a few weeks ago. The other day a carer said 'has anyone come to see you about the catheter', That was a week ago and I've heard nothing since."

Staff support: induction, training, skills and experience:

● Staff told us they were happy with the training they could access. They had an induction training which comprised of attending training courses as well as shadowing a more experienced staff member to get familiar with their job roles. Staff told us they did not have regular formal supervisions but managers were approachable should they needed 1-1 support. One staff member said, "All the managers and nurses are approachable including the [registered] manager and I can ask for support if I need. Supervisions are not as regular." Supervisions had recently started to be completed through one to one meetings and group supervision.

● Staff completed an induction programme at the start of their employment. New staff told us they shadowed experienced staff until they were deemed competent to work alone.

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

●The design of the building met people`s needs in terms of offering a spacious environment for people to easily access all areas using their mobility aids. However, on the corridors there was a carpet with small pattern which was not in line with recommended best practice when decorating an environment where people with dementia live. Some areas had received refurbishment and people told us they liked how it looked.

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

RI:□People did not always feel well-supported, cared for or treated with dignity and respect.

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

● People had been involved in the initial planning of their care. Some people felt that they were not listened to in regards to some decisions about their care. For example, when to go to bed and get up and the use of equipment. One person told us, "No no one talks to me about my care – I've not had a meeting that I can remember."
● Family members told us they saw the care plans when their relatives moved into the home and they had been asked in the beginning about the person.
● There was inconsistent information in care plans to evidence people`s involvement in their care. For example, the night support care plans were personalised to reflect that people were asked if they wanted their lights on or off or if they wanted their door open or shut. However, there was no such information provided for day time and we saw people`s bedrooms door were left open routinely if they were in their room for the day or in bed.
● Staff had an understanding of individuals likes, dislikes and preferences in some cases. Some staff did not know about people and directed us to the nurse for additional information.

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

●People told us staff respected their dignity and privacy. However, due to care that was not timely or personalised, dignity was not always promoted. For example, we heard people calling repeatedly and staff were busy elsewhere so could not go to them. In one instance the person was sitting on the edge of their bed in their underwear with the door open.
● People looked clean and in most cases well groomed. However, a relative reported times when this was not the case. Another relative told us, "You have to keep on top of them. No shower for ages, I just keep on and on. I came in one day and [person's] face was filthy and they had sleep in their eyes – that's after lunch – they clearly hadn't had a wash of any sort."
● Staff told us that the maximum number of baths or showers they could offer in a day was for three people. This meant that people were not routinely offered the choice of a daily shower or bath.
● People told us that they often waited for long periods of time to use the toilet. One person told us that they had soiled themselves as staff did not check them in the night.
● People's records were held securely in a lockable cabinet within a locked office to help promote confidentiality.

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

●People and their relatives told us staff were nice, kind and caring. One person said, "All the staff here care and work hard, there just aren't enough of them." A relative told us, "The staff are all lovely."

● Staff were seen to be attentive when supporting people. One staff member was assisting a person who was hard of hearing and the staff member had a whiteboard on which to write and communicate with the person. Other observations included staff checking on people, providing reassurance. Interactions overheard included, "There we are – now you can sit in your comfy chair." And "Now would you like to sit here, I will turn up the TV and then you can hear better."

● We saw staff comfort people who were upset or anxious, one said, "Please don't cry, your [relative] will be here soon." and gently stroked the person's hand. One staff member put a friendly arm around a person who was very anxious and said, "Come along with me, we will walk together."

Requires Improvement

Is the service responsive?

Our findings

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

RI:□People's needs were not always met. Regulations may or may not have been met.

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

● Some people told us that care was task led and staff were often busy causing a delay in support. They also told us that they were offered bed baths instead of baths and showers. One person wanted a shower as said they felt dirty but staff had told them they were unable due to a health issue. No consideration had been given to how they may have achieved the person's request. Another person told us, "I'm happy here, they help me get up and wash, they give me a bath." A third person said, "They don't ask me so I ask them if I need something. I have a (key worker) but they keep changing so I never have the same one and one says 'I'll sort 'it' and then walks away and of course nothing happens."
● People's relatives gave mixed views about the care. One relative told us, "[Person] has improved a lot since being here, they eat well, has really settled in, has had their eyes tested and is knitting again. They have decreased their medication too."
● Care plans did not always reflect people's needs in a person-centred way, likes and dislikes or preferences. Some plans did not include information needed or demonstrate processes used to reach a decision. For example, for the use of bedrails. The management team had identified that care plans needed further work.
● Activities needed to be improved. One person said, "Same old stuff or nothing at all – usually just TV – but every so often we get some great entertainers in – they come to one unit and everyone that can goes over – really good just not very often." A second person said, "Nothing happens, but it's alright (here)."
● There were no activities seen on the day of the inspection and staff told us these were not always happening. There were activity boxes with resources but we did not see these being used. A relative told us, "Activities are a big problem here – nothing much going on day in day out. There were five activity organisers – they've all left then a new one came .... and left quickly." The manager told us that they were recruiting for activity staff. People who were in their rooms had very little social stimulation.

End of life care and support:

● The service offered end of life care to people. However, planning for what support people should receive in their final days or their wishes had not been developed in most plans we reviewed. One relative said, "They [staff] only wanted to know what undertakers to call and if [person] wants to stay here or go to hospital if they decline."
● Staff had been given step by step guidance from the manager about their expectations in regards to care delivery during a recent staff meeting.

At this inspection we found the provider in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care was not delivered in a person centred way

and opportunities for activities provided needed to be improved.

Improving care quality in response to complaints or concerns:

● People told us they had not made any formal complaints about the service. People told us they would speak with the nurse if they needed to raise a concern.
● People's relatives told us that they knew how to raise concerns. However, one person said, "Meeting dates are up on the board, not many people turn up and when we ask for things they don't do them anyway. We asked for a hedge to be cut, well a big trim and they said 'yes' and then ignored it."
● Complaints received were investigated and action was taken to address concerns and where appropriate lessons were learned as a result of the outcome.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care:

- People and their relatives gave mixed views about any improvements in the service.
- People told us that things have deteriorated. A relative told us, "Over the [number of] years [person] has been here things haven't improved and in the last year generally it's gone downhill." Another relative told us, "The new broom has swept clean, they spent a lot on redecorating the sitting room, then realised how much they had spent and stopped." We were also told, "Lots of staff have left so now we are left with short staff, agency staff and no activities – not good is it."
- The manager and provider were aware there had been areas that needed to be addressed in the home. They had planned opportunities to meet with people and their relatives to listen to their views and address any issues. A relative told us, "I completed a satisfaction survey recently." The manager told us that they had been managing challenging staffing issues which had been necessary to drive improvements in the home and change the culture in the home. They told us that they hoped the improvements would now be able to be embedded. The progress had been slow.
- Following a survey, a plan of what was to be improved was developed and shared on notice boards. This included improvements to staffing, activity staff, the environment and updates to policies and processes to be shared with staff.
- However, the provider had not shared learning from their other locations into this service. There had been similar issues found in another of the provider's locations and this had not ensured the provider had made the required improvements across all locations.
- The service had deteriorated since our last inspection and now had numerous breaches and a rating of inadequate. We asked the provider to carry out a root cause analysis to ascertain why they had failed in this area and we were awaiting their response at the time of this report.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

- At the previous inspection in February 2018 people's records needed to be completed more accurately and consistently.
- At this inspection we found people's records to still be an issue in some cases. The manager was carrying out regular checks to try and address the shortfalls and prompt staff. However, care plans, fluid charts and records relating to MCA and DoLS remained a concern.
- There had been few opportunities over recent months for people and their representatives to share their

views about the quality of the service provided. One person told us, "We used to have meetings – someone from the kitchen or a manager or a nurse would come and talk to us and then ask us about what we would like but they don't have that anymore."
● Meetings and surveys had recently started and more were now planned. One relative told us, "I go to the relative's meetings every three months, everyone is asked if they are happy with the care, it's very useful."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

● Staff told us the new manager was approachable and listened to staff but progress to improve the service was slow. One staff member said, "The manager is good. She comes and listens. It's just slow [progress]." Another member of staff said. "I can talk to the manager. they have an open door policy."
● The area director told us that the manager had had a challenging few months with addressing issues with staff and managing disciplinaries but the provider felt that they had managed a difficult situation well.
● The role of manager was new to the current manager and the provider needed to ensure sufficient and regular support was in place. The manager told us that they had a buddy of a senior manager who they met at monthly manager meetings and could speak with on the phone. The home was visited by a quality team monthly. However, the manager had been without a deputy manager and without a unit manager on one unit and the provider did not place additional support in the service for them.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

● People knew who the manager was but gave mixed views on how often they saw them. One person said, "I know it is [name] and I've seen her, maybe once." Another person told us, "Sometimes [name] flits in and then flits out again – seconds maybe."
●People's relatives told us they were happy with the new manager. One relative said, "I have met the new Home Manager but I haven't seen her around the home. She is talking about holding a [meeting] every six weeks for relatives." Another relative said, "I have met the new manager, she gave me her email address to use if I had any problems."
● Staff told us care was not personalised and relatives confirmed this. Care plans were inconsistent in format and quality of information recorded.
● There was a range of audits and quality checks to help find and address shortfalls. Some issues had been found by the manager and the quality team but they had been unable to address all the issues. Some issues, such as those relating to risks, had not all been identified prior to our inspection

Working in partnership with others:

● The service was working with the local authorities and clinical commissioning groups to ensure they were providing a service in accordance with their contracts. Shortfalls found by these agencies were included in actions to enable them to monitor the progress.
● The provider was in regular contact with the local authorities to discuss improvement plans and we were part of this process. However, the improvements had not yet been achieved.

Due to a failure to bring about the required improvements in a timely manner and further concerns identified on inspection, we found the provider in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Care was not delivered in a person centred way and opportunities for activities provided needed to be improved.

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 Infection control was not always promoted, fire records needed to be completed, unexplained bruises and skin tears were not always robustly investigated, medicines records needed to be accurate and risk assessments needed to be consistently in place and followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems within the service did not consistently ensure people were protected from the risk of abuse.

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 failed to bring about the required improvements in a timely manner and further concerns were identified on inspection.

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 People's needs were not always met in a timely fashion.