Eastgate Care Ltd

Canal Vue

Inspection report

107 Awsworth Road
Ilkeston
Derbyshire
DE7 8JF

Tel: 01159791234
Website: www.eastgate-care.co.uk

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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

This unannounced inspection took place on 12 September 2018. At the last inspection the overall rating for this service was Inadequate which means it was placed in special measures. At this inspection the overall rating for this service is 'Inadequate' and the service will remain 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.

Canal Vue 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 care is provided in one building across three floors. At the time of this inspection people were only living on the ground floor. There are communal living areas and a separate dining area on that floor. The home provides accommodation and nursing care for up to 70 people who are living with dementia. However, after our last inspection they were not able to take any new admissions and there were now 13 people living at the home.

There was not a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was an interim manager on the day of the inspection visit and a new manager due to start the following week.

We found that risk was not managed sufficiently to ensure that people were kept safe. Staff had not received additional training in supporting people living with dementia and we found that they were not always skilled in assisting people whose behaviours put themselves or others at risk of harm. Risk assessments and care plans were not always regularly reviewed to take account of all incidents which had occurred. Staff did not always recognise and report suspected abuse. The provider did not always learn from when things went

wrong to ensure that action was taken to avoid it happening again. They did not ensure that staff understood how to avoid further recurrence.

At the previous three inspections we found that the Mental Capacity Act 2005 (MCA) was not fully embedded, we found some improvements at this inspection. Capacity assessments had been completed to assist people to make decisions which were in their best interest. However, staff were not aware who had safeguards in place when there were restrictions on their liberty. They also did not demonstrate an understanding of when restrictions could be applied. Therefore, 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; the policies and systems in the service did not support this practice.

Quality improvement systems were not consistently completed and there was limited provider oversight of the actions required to improve the service. This meant that risks to people's safety and wellbeing were not actioned sufficiently and lessons were not learnt when things went wrong. There was no provider oversight of complaints received to ensure that the procedure was managed by a registered person. There were no regular meetings or other ways of getting feedback from people who lived at the home and their relatives to evaluate and improve the service.

The provider did not always comply with the requirements of their registration. Notifications of incidents and events were not always made, they had not reviewed their statement of purpose in line with changes to the service provided and they did not always report as they were required to do after their last inspection.

Care plans were not always up to date or regularly reviewed to ensure that staff had relevant information to assist them to support people. This included plans for people who were at the end of their life.

People did not always have their dignity and privacy respected. They did not always have enough stimulation and engagement in activities.

There had been some improvements since the last inspection. Medicines were managed and administered effectively to ensure that people had them as prescribed. There were enough staff deployed to meet people's needs. Safe recruitment procedures were established to ensure that staff were safe to work with people. People had enough to eat and were offered a choice at mealtimes.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

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.

People were not provided with safe care and treatment because risk was not always fully assessed nor were plans put in place to reduce it. People were not protected from the risk of abuse because safeguarding concerns were not always recognised or reported. The risk of infection was not always adequately controlled. Medicines were effectively managed to reduce the risks associated with them. There were enough staff to meet people's needs safely and safe recruitment procedures were established.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always have the skills and training to support people effectively. They did not always understand how to support people who were not able to make their own decisions. People's health needs were not always met. People did receive the support to eat and drink what they needed. The environment was suitable to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy was not upheld. Their choices were not always respected. Families were able to visit when they wanted to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their needs and preferences. Their care records were not always up to date or accurate. There were not always enough activities provided to engage people. Complaints were not always managed to ensure that they were responded to and that people were happy with the outcome.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to monitor and drive quality improvement were not consistently completed and were therefore not effective in improving the service. The provider had not made the required improvements since the last inspection. They did not provide opportunities for people and relatives to feedback about things that needed to be improved. They did not notify us of all incidents that they are required to or meet all of the requirements of their registration.

Canal Vue

Detailed findings

Background to this inspection

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

This inspection took place on 12 September and was unannounced. It was completed by two inspectors and a specialist advisor. The specialist advisor provided support in inspecting leadership and governance.

We used information that was shared with us by commissioners of the service to assist us to plan our inspection. We also used information we held about the home which included notifications that they sent us. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). 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. However, we ensured that the provider had the opportunity to do this during the inspection visit.

We used a range of different methods to help us understand people's experiences. We spoke with three people who lived at the home about their experience of the care and support they received. People who lived at the home had variable verbal communication and some people were living with dementia. Therefore, we observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit. We also spoke with two visiting relatives to gain their feedback.

We spoke with the interim manager and interim deputy manager, the operations manager, the senior care staff and three care staff. We also spoke with a visiting healthcare professional and fire officers who were completing an inspection of the building. We reviewed care plans for six people to check they were accurate and up to date. We also looked at medicines administration records and reviewed systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included safeguarding records, accidents and incidents analysis and complaints. We asked the operations manager to send us information within two days about action taken to ensure the building was safe after feedback from the fire officers. They did not do this within the agreed timeframe and we had to remind them.

Inadequate

Is the service safe?

Our findings

At our last inspection we found people were not always protected from abuse and improper treatment, and there was a breach of Regulation 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that no improvements had been made and people remained at risk of harm. We saw that one person had an injury. We spoke with their relative who they told us they were unsure how it had happened. When we spoke with staff about this they were also unsure. We saw that the injury had been recorded but no investigation had taken place into how it had happened nor had it been reported to the local authority safeguarding adults team.

Some people were subject to unauthorised restrictive practices. When we spoke with staff about the person they told us that they sometimes resisted personal care and it needed three members of staff to stop the person harming themselves or others. They said that at times they held the person's arms to achieve this. We saw records which evidenced that this had happened on occasion. We reviewed the person's care plan and found that this intervention had not been assessed and there was no guidance in place to direct staff. Staff had not received training in restraining people safely and therefore this physical intervention was not safe.

There were also records of incidents which had occurred between two people who lived at the home. For example, on one occasion one person had grabbed another's arm when they were agitated. This had not been reported as a safeguarding concern nor as an incident so it was unclear what action had been taken to protect the people afterwards to prevent the harm happening again. We had concerns about this at our last inspection and found that this had not improved at this inspection and staff were still not recognising these incidents as safeguarding concerns.

Action was not always taken after safeguarding concerns were raised to ensure that the risk of recurrence was reduced. One safeguarding related to professional guidance not being followed to ensure that one person received topical creams to manage sore skin. At this inspection we found that there was a delay between another person having topical creams prescribed and them being administered in a timely manner. In addition, after the inspection visit we were notified of a third occasion when there was a delay in treating sore skin with topical medicine. This demonstrated to us that the provider was not effective in ensuring that lessons were learnt from when things went wrong to protect people from potential and ongoing abuse or harm.

This was an ongoing breach in Regulation 13 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At our last inspection we found that risk was not always managed to protect people from harm, and there was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that improvements were still required in the areas we identified.

Some people behaved in a way which could cause themselves or others harm. We saw that one person was

distressed and didn't understand when staff asked them to move to another room for a meal. The member of staff continued to ask and this increased their anxiety. Other staff approached the person to encourage them to move but their distress escalated. The situation was resolved when staff asked the manager if the person could eat their meal where they were seated. The staff had not recognised that their interaction was increasing the person's distress. When we reviewed records for the person we saw there were regular periods when they were upset which led to aggression towards staff. We spoke with one member of staff who said, "I find the behaviour the hardest to manage. I'd like to know more about how to manage it. The other day after an incident I asked the person not to do it because it hurt. A senior member of staff said I shouldn't have said that but when I asked what I should do they didn't have any advice." When we looked at the risk assessments which were in place to guide staff they were vague and said, 'When expressing anxiety and distress use distraction techniques.'

We looked at the risk assessments for other people who could behave in a way which could cause harm to themselves or others. We found that the majority were limited in the guidance they gave to staff. For example, another said, '[Name] can sometimes become agitated which can lead to aggression. Should be documented in 'ABC'. Staff to offer reassurance.' ABC charts are Antecedent, Behaviour and Consequence and they aim to capture all the information around a behaviour to analyse what may be causing it and what the behaviour achieves for the person. We looked at the ABC charts for people and found there was limited information recorded; for example, one record just stated the person was 'left to calm down.' The information was also not evaluated to consider what triggers there may be for the behaviour. There was no review of the charts and the information in them had not been used to review care plans. For example, when there had been incidents between two people the risk assessments were not reviewed in response to this and amendments were not made. This meant there was a risk people may not receive safe support that met their needs.

Lessons were not always learnt when things went wrong. We saw that a system was used to record falls and it was clear what action had been taken as a consequence; for example, referrals to other professionals. We were assured by the interim manager that this was an effective system and there was good oversight of any accidents or incidents. They told us that there was no record for September because there had been no accidents in that month. However, we saw that two people had injuries and when we asked staff they told us about the accidents that had caused them. Incident forms had been completed but they had not been reviewed by a senior member of staff. This demonstrated that the systems were not effective in reviewing accidents in a timely manner to consider if any changes needed to be made to people's risk assessments to reduce the ongoing risks.

The risk of infection was not always controlled to ensure people were safe. Some people used a hoist to assist them to move and the slings that they used for this were not labelled. When we asked staff they told us that they did not know which sling belonged to which person. We looked at the slings in the storage cupboard and found that there was a strong odour of urine coming from some of the slings. This meant there was a risk people were sharing soiled slings which could spread infection. We also found that the cupboard contained old cushions which also had a strong smell of urine from them. This was not a hygienic practice.

There was an assessment by the fire service on the day of the inspection. They found that some people were at risk of harm from fire. For example, battery charging points were stored in a protected staircase causing a hazard and an ignition risk. There were also combustible materials such as cardboard boxes and mattresses in the staircases which again increased the risk of fire to the people living at the home. This showed us that the provider had not ensured that the environment was safe for people to live in.

At our last inspection we found that recording of prescribed topical creams records was not always completed. At this inspection we found that a new system had been introduced so staff could see where the cream should be administered on a body map and there was a separate medicines administration record (MAR) so that the staff who applied it signed for it. However, we saw some of these had not been signed for the previous two days and therefore we could not be certain that they had been applied. This may have had a negative impact on the health of people's skin.

This was an ongoing breach in Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

There were some improvements in other risk management. We observed that when people required assistance to move this was done safely and in line with their care plans. For example, after a fall one person was advised to be supervised when they mobilised independently and we saw staff accompany them when they walked. Other people had specialised mattresses when they were at risk of skin damage and we saw that the settings on these were regularly reviewed and recorded to ensure they were effective.

There were also improvements in the management of other medicines. We observed that medicines were administered patiently and that staff took time to ensure that the person had taken them. When people were prescribed medicines to take 'as required' there was guidance to support staff to understand how many they should take in a certain timeframe. Medicines were stored, recorded and monitored to reduce the risks associated with them.

At the last inspection there were not enough staff to meet people's needs. This had improved and we saw that there were staff available to support people. We saw that there were staff available in communal areas and that they had time to spend with people. Staffing levels were planned around individual need and that staff were assigned roles on each shift to ensure people's needs were met.

Safe recruitment procedures were followed to ensure staff were safe to work with people. There had been no new people employed since the last inspection and previous risks had been resolved.

Requires Improvement

Is the service effective?

Our findings

At our previous three inspections we found there was not enough training and support for staff to understand how to support people living with dementia. At this inspection we found staff had still only received limited training in supporting people living with dementia as part of their induction training. One member of staff told us, "I still haven't had dementia training. I've wanted it since I started." When we spoke with the interim manager they acknowledged that the training to date had been limited and they told us that they had contacted the dementia outreach team to provide some support in the next month. One of the actions we took after our last inspection was to ask the provider to assure us that staff had received additional skills development in supporting people living with dementia. We had been told that they were completing workbooks and reflective practice. When we asked about this no one could show us a completed book and this training was not recorded on the staff training record.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff did not understand the MCA or how to support people who had a DoLS in place. They could talk to us about people's capacity to make their own decisions and were able to identify some people who could. When we asked who could leave the building unsupported one member of staff told us, "I wouldn't let any of them out without staff. Not even if they asked." Two other staff we spoke with also said that they would prevent all people who lived at the home from leaving without support. This demonstrated to us that staff did not understand that people could only be restricted if it was in their best interest. They did not consider that some people may have capacity to understand the risks of leaving the building and it would be their decision.

The training record stated that 88% of staff had training in MCA and DoLS. We asked staff about the training. One member of staff said, "I might have had training on it when I started, but not since." Another member of staff told us they were unsure what training they had received, they were not aware of mental capacity assessments nor Best Interest Assessments for anyone. This showed us that the training did not provide staff with the skills and knowledge required to understand and support people under MCA and DoLS.

This evidence represents an ongoing breach in Regulation 18 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

We checked other principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. When we asked staff and the interim manager who had a DoLS in place we received different answers. It was also difficult to ascertain which applications had been authorised that the

interim deputy manager telephoned the local authority authorising team to confirm. We found that there were none in place but several applications had been made when people required them. They were awaiting authorisation from the relevant authority.

There were also best interest assessments in place for a lot of decisions. This was an improvement since the last inspection. However, the best interest decisions and DoLS applications did not always contain as much detail as other records to demonstrate why the safeguard was required. For example, one person's DoLS application stated that they required staff to provide their medicine. However, records demonstrated that they often refused them and the best interest decision only covered the basic administration of medicine. It did not reference the repeated refusal or how staff could address this in the person's best interest.

We recommend that all best interest decisions and DoLS applications contain current information about people's capacity to make their own decisions.
People received variable support to assist them to manage their health. There were safeguarding concerns about health professional's guidance not being followed which resulted in a deterioration in skin care. This demonstrated to us that staff did not always work across other organisations to ensure people received consistent, timely care and support. However, we also spoke with one health care professional who praised the staff for supporting people to manage a person's health condition. For example, they worked with the team to train them in how to support someone with a specific health need. The staff team had cascaded the training to other team members and the health professional saw that the condition was well managed and reported that the person was happy with the care.

The assessments of people's needs were not always made in line with evidence based guidance. For example, one person had an assessment to manage their skin. Although it contained information about pressure relieving equipment it did not reference how often the person should be repositioned. The National Institute for Health and Care Excellence (NICE) states, 'Encourage adults who have been assessed as being at risk of developing a pressure ulcer to change their position frequently and at least every 6 hours.' Other assessments were in line with national guidance. For example, a care plan contained detailed information about managing chest infections which included how to support the person and when to refer to other professionals.

People received enough support to eat and drink and this was an improvement on the last inspection. There were three choices of food at lunch and people were shown the different food so they could decide which one they wanted. When people required support to eat this was given in a patient and kind manner. Some people required specialist diets and staff were knowledgeable about that. Drinks were offered to people frequently throughout the day and we saw fresh fruit was available as snacks. One relative told us, "They have recently started putting fruit out for people."

The environment had been designed to meet the needs of people living with dementia when it was built. Some changes had been made in recent weeks to consider how the space could be used more effectively to meet people's needs. For example, a lounge which was not frequently used was converted to a dining area so that people didn't eat in the same communal area that they sat in.

Requires Improvement

Is the service caring?

Our findings

Dignity was not always respected for people living at the home. We found that this was a concern at the last inspection and it continued to be at this one. Staff did not always respect people's privacy when they spoke about them. For example, one person was prompted about requiring personal care from a member of staff from across a communal space so that everyone in the room could hear it. Another person was wearing a shoe which didn't have a lace in it and was hanging off their foot. The member of staff supporting them told them they would ask their relative to replace the shoes later rather than resolving the situation so that the person was dressed in a dignified manner. A third person had asked for assistance with personal care but the member of staff had forgotten to request support. This meant that the person had to ask us to follow it up and they told us they were embarrassed about this.

At other times, we observed some kind and respectful interaction between staff and people they were supporting. We saw people responded positively to staff holding their hands or talking to them. Relatives we spoke with told us that staff were caring and that they trusted them. However, one relative also told us that a lot of staff that their relative liked and responded to had left since the last inspection and this had a negative impact on them. One member of staff told us, "I love my job and we all really love the people. It has been hard with all the uncertainty and change though."

People were not always given choice about the care they received. For example, staff told us about needing to encourage one person to bathe regularly. However, they also said that the person understood the risks of not bathing and had chosen not to before moving to the home. Other people did make choices about where to spend their time; for example, several people chose to spend time in their rooms and were supported to do so.

Relatives were welcome to visit anytime and could see people in privacy. The manager was aware of advocacy support; however, no one was currently accessing this. Advocacy services are independent of the service and the local authority and can support people to make decisions and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found there were not always plans in place to capture people's wishes at the end of their life. At this inspection we found little improvement. One person was identified to us as having been assessed by health care professionals as nearing the end of their life. We looked at their care records and found that the only end of life information recorded related to what to do in the event of the person's death; for example, their funeral plan. This was completed before the health professional's assessment. There was no information recorded about how they wanted to die; for example, where they wished to be, any cultural or spiritual wishes, or how they wanted their pain managed. There was no record of family or friends being involved in planning this period of their life with them and staff. This showed us that the provider had not considered how to support people to have a dignified death of their choice.

Care plans did not always reflect the support that staff gave people or give clear consistent advice. Some of the information they contained was contradictory. For example, one person had a risk assessment for medicines which stated, '[Name] is happy for trained staff member to dispense their medication and stay with them as they take them. They take them with a drink of juice.' Their medicine care plan stated, '[Name] can refuse it so the trained person giving them medication has to go back again a few minutes later and try again. This works and they normally take it second time.' The evaluation for this care plan recorded non-compliance with taking the medicines. For example, 'Can occasionally refuse and spit them out', and 'mainly accepting of medication and only occasionally refuse them'. Therefore, the information in the care plan had not been reviewed and updated so that staff had current guidance. This placed the person at risk of inconsistent support.

Another person was supported by a member of staff to eat a meal. The staff member continuously prompted the person to swallow their food. They told us that the person sometimes didn't swallow and forgot to continue eating so they provided this support to ensure they had enough to eat. We saw that the person smiled and was calm throughout and seemed to enjoy the interaction. We reviewed the person's care plan and saw that it only said they had a good appetite. It had not been updated as the person's dementia had progressed to show that they now needed continual prompting throughout a meal.

Some daily monitoring records were not fully completed to ensure that people had the care they were assessed to need. For example, some people had fluid charts in place to ensure that they had a minimum amount to drink each day. When people had not drank all of the fluids needed in one day, action was not always taken to monitor them. For example, one person's fluid intake was recorded as two thirds of the required amount on three consecutive days but no action was taken. A system had been introduced two days prior to the inspection visit where senior staff reviewed everyone's risk. It had been effective for another person because a healthcare professional was called to assess their health. However, it was not consistently applied to ensure wellbeing was regularly reviewed and care altered to promote wellbeing.

Some people who lived at the home had disabilities and sensory impairments. The provider had not complied with the Accessible Information Standard (AIS). This was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand. Information had not been

shared in an accessible way for people who lived at the home. For example, the complaints procedure was not shared with people who could no longer read using pictures or a recording.

People's personal histories were not always considered when assessing their care, including their spiritual and religious beliefs. One person's pre- assessment stated their religious beliefs as 'unknown'. This was not reviewed at any other point and they were therefore not given the opportunity to attend religious services.

This evidence represents an ongoing breach in Regulation 9 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have enough encouragement and interaction to engage in activities. There was no longer an activities co-ordinator employed at the home. One relative told us, "We all liked the entertainment staff but they have not been replaced. There are not a lot of activities provided now." Staff told us that they could provide activities on some days. One member of staff said, "We have had some activities provided by staff from another of the provider's homes and staff here are able to do more. We are planning to work on some craft today." However, on the day of our inspection visit staff had little free time to engage people in activities and they spent most of their day sitting in a communal area or in bedrooms with little interaction.

At our last inspection we found that complaints were not always managed and responded to thoroughly to ensure that lessons were learnt and that complainants were satisfied with the outcome. There was a breach of Regulation 16 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found one record of a complaint which the previous registered manager had responded to. However, when we asked the interim manager and the operations manager about the process for reporting complaints to the provider they told us that would not routinely happen. We were aware that nine people had chosen to leave the home since our last inspection but there was no record that any of these people or their relatives raised any concerns about the standard of care before they left. Relatives we spoke with told us they had not received any information from the provider about changes in the management of the home. This included information about who they should raises concerns or complaints with. This demonstrated to us that the provider did not ensure that the complaints procedure was overseen by a registered person nor that there was a satisfactory response given to any concerns raised.

Inadequate

Is the service well-led?

Our findings

At the last inspection we saw that the systems in place to measure and drive improvement were not effective and we rated the service as inadequate and placed it in special measures. We imposed conditions against the provider's registration which meant that they could not take any new admissions to the home without the permission of CQC. They were also required to tell us what staffing levels were planned and how they would ensure staff had sufficient training to do their roles; particularly in understanding dementia. On three occasions we had to prompt the provider to give us this information as required.

At this inspection we found that they had not met the condition of providing staff with additional training in dementia despite providing us with assurances that they had. We also found that although the number of people living at the home had decreased from 58 at the last inspection to 13 at this inspection there had been little improvement in managing risk, understanding safeguarding, ensuring people's care plans were current and regularly reviewed and protecting people's dignity and privacy. This continued to have a negative impact on the people who lived at the home.

There was not a registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Three weeks prior to the inspection visit additional support had been provided to the home by an interim manager and deputy manager from another of the provider's homes. One member of staff told us, "We weren't getting much support. This has really picked up since the interim manager came in." Another member of staff said, "It's a really good home. The staff are good and we really try; but the problem is higher. The management and provider just don't support us and so staff leave."

The provider had not ensured sufficient oversight of the home since the inspection in March 2018 to ensure that sufficient improvements were made. Audits and checks of the quality of the home were not regularly completed and there was no system in place to report actions to the provider. There was an operations manager who visited the home to provide support. They confirmed that there was no systematic oversight of the quality of the home or expectation for managers to report to them or to the provider.

Risk was not always assessed, monitored and mitigated to ensure that people who were living at the home were safe. When safeguarding concerns were raised there was not always a thorough investigation nor actions taken to reduce the risk of it happening again. For example, we were notified by the previous manager about an accident that occurred to a visiting health professional in the home. We asked the interim manager and senior care staff what actions had been taken to reduce the risk. None of these staff were aware of the incident and could not assure us that any actions had been taken. We checked the action we were told about in the notification and found that it had not been put in place. This demonstrated to us that there was limited oversight of safeguarding and safety concerns.

The provider worked closely with partner organisations who provided regular guidance and support. They

had an improvement plan in place with commissioners of the service and had not met all the requirements on it. This had resulted in suspension of placements until they could demonstrate that they could meet people's needs. There was repeated delay in implementing improvements as identified on this improvement plan. For example, after a safeguard investigation where professional guidance was not followed it was identified that there should be senior staff oversight of a handover report each day so that people's current wellbeing could be regularly monitored. This was agreed on 15 August 2018 but was not fully implemented until 10 September 2018. This delay in implementing the agreed action put people at continued risk of harm. In addition, action which the provider stated had been taken was found not to have been. Assurances had been given that all behaviour monitoring forms had been reviewed and the information in them used to review and amend risk assessments and care plans. We found that this was not the case because we found information about people's behaviour in records which had not been used to update their care plans.

The provider had not used feedback from people, their families or the staff who worked at the home to evaluate and improve the service. One relative said, "I knew the previous manager and we had regular meetings with them but nothing really happened afterwards." Another relative told us, "I haven't received any information from the provider since they informed us that they would no longer be doing nursing care. I have really lost confidence in them. We haven't been informed of the manager leaving or what is happening."

Staff didn't receive the support they required and didn't feel listened to. When we asked one member of staff about supervision they told us, "We always get called into the office when we do things wrong and they tell us they are unhappy. I have had one appraisal since I started. They talk about doing them more often but it hasn't happened." Another member of staff told us they didn't feel consulted. They said, "They just do what they think is needed."

The service had been judged as requires improvement or inadequate for the past four inspections. At this inspection we found that insufficient improvements had been made to ensure people were safe despite a significant decrease in the number of people supported. They also remained in breach of regulations. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive.

This was an ongoing breach in Regulation 17 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not informed us of all the incidents that they are required to under their registration with us. We were informed of a safeguarding investigation by the local authority prior to our inspection visit. It had occurred the previous month and the provider had not sent us the notification they are required to under their registration with us. This meant that we could not monitor and review the provider's response to such incidents.

This was an ongoing breach of regulation 18 of the Registration regulations (2009)

Providers must produce a 'Statement of Purpose' which explains the aims and objectives of the service, the kinds of services provided and the range of service users' needs which those services are intended to meet. They must notify CQC of any changes to their statement of purpose and ensure it is kept under review. In March 2018, the provider told us that they would no longer be providing nursing care to people. After the last inspection we reminded the provider of their duty to change their registration with us. At this inspection they had still not updated their registration. They had also not amended their Statement of Purpose to reflect

this change.

This was a breach of regulation 12 of the Registration regulations (2009)

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home and on their website.

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The provider had not ensured that the information in their Statement of Purpose was updated and current.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents CQC were not always notified of significant events in line with the provider's registration.

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 People did not always receive care that was person centred.

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 People did not always receive safe care and treatment.

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 People were not always safeguarded from

abuse and improper treatment

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 systems and processes in place to manage the service were not always effective.

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 Staff did not always receive appropriate training and support to enable them to carry out their duties effectively.