Silver Healthcare Limited

Leahyrst Care Home

Inspection report

20 Upperthorpe
Sheffield
South Yorkshire
S6 3NA

Tel: 01142722984
Website: www.silver-healthcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Leahyrst Care Home is a residential care home providing personal and nursing care for up to 41 people aged 65 and over, some of whom are living with dementia. On the first day of our inspection there were 35 people living at the home and on the second day of our inspection there were 33 people. The home has three floors.

People's experience of using this service and what we found
People did not always receive safe care. During this inspection, we identified and reported several safeguarding concerns. People's medication was not administered safely, and people did not always have medication available to meet their needs. Risks to people's care were not managed safely. During this inspection, we could not be sure the equipment used to support people was always safe. The environment was not always clean and free of odours. Staff were not recruited safely.

The provider failed to ensure people's nutritional needs were always met. People were not always supported to eat in a caring or considerate way. Several people living at the home had lost weight and appropriate action had not always been taken in a timely way. People living at the service told us the food was not always appetising or varied.

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. We found blanket restrictions for people living at the home. Some people required a deprivation of liberty safeguards, their order had conditions but the provider was not complying with them.

Staff had not been supported to have the appropriate knowledge and skills to deliver safe and effective care. We found training was not kept up to date and staff were not offered regular supervision or appraisal meetings. We found concerns about the staffing levels, in particular during the night period.

People did not always receive person centred and dignified care. Some people's care plans were inaccurate and lacked information about people's needs which meant staff were not provided with clear guidance to support and care for people. People's end of life wishes were not always documented appropriately. Although people and relatives told us staff were kind, our findings did not indicate the home was consistently providing a caring service that always respected people's needs.

The provider did not have effective processes in place to handle complaints. People were not offered regular opportunities to interact and we found there were no structured activities happening during our inspection visits.

Quality assurance processes were not effective in identifying the issues found at this inspection and in driving improvements. Records were not always accurate, complete or kept safe.

We found widespread shortfalls in the way the service was managed, in particular a lack of management oversight and accountability. There was a risk of people receiving inappropriate care. There was no registered manager. A new home manager had recently been appointed and was in post on the second day of our inspection. The nominated individual did not have good oversight of the day to day running of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published 6 July 2017).

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

Enforcement
We have identified breaches in relation to the safety of the care delivered to people, safeguarding people from abuse and neglect, lack of person-centred care, poor support with nutrition and hydration, failure in ensuring adequate and appropriately trained staff and lack of appropriate management oversight at this inspection.

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

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Leahyrst Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was conducted by one inspector, one nursing specialist advisor and an Expert by Experience on the first day and two inspectors on the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. For the purpose of this inspection, that experience was in caring for people with dementia.

Service and service type
Leahyst care home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A new manager had recently been appointed and we spoke with them during the second day of our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the CQC. A notification is information about important events which the service is required to tell us about by law. We requested feedback from other stakeholders. These included Healthwatch Sheffield, the local authorities safeguarding teams, commissioners and fire service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
During the inspection, we spoke with ten people using the service and four relatives of people using the service. We spent time observing care in the communal lounges. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three healthcare professionals visiting the service.

We spoke with eleven staff members; this included the home manager, the supporting manager, deputy manager, senior care workers, care workers, cook and administrator. We looked at full care records for four people living at the home and sampled care records for other seven people. We looked at training, recruitment and supervision records for staff. We also reviewed various policies and procedures and the quality assurance and monitoring systems of the service.

After the first day of our inspection, we shared our initial findings with the local authority, including safeguarding concerns. We sent a letter to the nominated individual with a summary of our concerns and asked them how they would address them. We reviewed their response and actions on the second day of our inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found and updates on the immediate actions we asked the provider to take. We continued in contact with the local authority and also shared the findings of this inspection with the fire service.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of harm. During this inspection, we shared safeguarding concerns with the local authority because we found unexplained bruising to a person had not been reported or investigated, people had lost considerable weight in a short period of time and appropriate referrals had not always been made, medication was not always available to meet people's needs and timely oral health assistance was not offered to a person.

● Staff were able to describe signs of abuse and neglect however, their training had not been effective because they had not identified or acted appropriately on the concerns we found. The new home manager was clear on their responsibilities about reporting safeguarding concern and told us the work they had planned to develop staff's knowledge in this area.

We found the systems and processes in place were not operating effectively to prevent abuse of service users. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe living at the home. One person said, "I like it here, it's nice, I feel safe." Relatives also told us they felt their loved ones received safe care. However, our finding from this inspection was that people did not consistently receive safe care.

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

● Risks to people's care were not managed safely.

● Risks to people had not always been assessed or planned to ensure they received care safely. Where risk assessments were in place, these did not always contain accurate or up to date information. For example, two people living at the home were known to display behaviours which could be challenging to others; one we observed being physically aggressive to staff and the other had risks identified in their DoLS order. There were no risk assessments indicating the risks these behaviours could pose to them, other people living at the home or staff. These people's care plans did not have specific guidance on what staff should do to manage these behaviours. We also saw behavioural incidents were not being recorded separately to enable an appropriate analysis to understand what had triggered them and what could be done to prevent or better manager them. Appropriate referrals to address the mental health needs of these people had not always been done in a timely way.

● The home recorded accident and incidents related with falls. However, the monthly analysis of this information did not highlight any trends or patterns. We noted that between September 2019 and January 2020 several falls had happened during the early morning period or during the night. The lack of appropriate

analysis meant the provider was not using this information to review staffing levels or staff deployment to ensure appropriate management of care to those at higher risk of falling.
● We could not be assured equipment to support people to mobilise was safe for people to use. During our inspection visit, the provider could not evidence slings used by people had passed the Lifting Operations and Lifting Equipment regulations. After our inspection, the home manager told us new slings had been purchased and checks on existing slings were in the process of being carried out.
● Environmental risks were not managed well. We could not be sure staff were always checking the temperature of the water before helping people to take a bath therefore putting them at the risk of being scalded. Monthly checks on the temperature of water in bathrooms and people's bedrooms was higher than recommended and taps did not always an appropriate thermostatic valve fitted. The management told us they were going to introduce these checks and contact the appropriate professional to review this equipment.
● We could not be sure people would be appropriately supported in case of fire. For example, people's personal evacuation plans were not up to date and staff who were designated as wardens had their fire training expired. We shared our fire safety concerns with the fire service.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager responded immediately during and after the inspection. They confirmed they were working to put in place appropriate arrangements to manage specific risks to people's care, environment and safety.

Using medicines safely
● Medication was not managed safely.
● People did not always have all their prescribed medication available. For example, one person had been losing weight and the GP had prescribed them supplements; these were not available on our first inspection day. Another person had been prescribed with spray to manage their skin integrity; this was not available during the first and second days of our inspection.
● There were no protocols for 'as and when required' medication to guide staff on when to offer and administer this medication. For example, one person was known to, at times, display behaviours considered challenging to others; staff were not offering this person with pain relief when this happened or used any pain scale to assess if they required it.
● Staff's knowledge and practice in relation to administration of medication was not always robust although the home manager told us they had recently had an assessment on their competencies completed by an interim manager.
● The home was completing monthly medication audits, but these had not been effective in identifying and addressing the issues found at this inspection. We asked the home manager to audit all the medication and take the appropriate actions to address any issues found.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People, relatives and staff told us staffing levels were not adequate. People commented, "No, not really enough [staff], they don't really have time to talk. I haven't had my breakfast yet; we have to wait for somebody to fetch us" and "Think they could do with a few more staff especially when they have to lift me." Relatives said, "No, don't think there is [enough staff], they are all rushed off their feet." Staff told us, "We need more staff."
● The provider was using a dependency tool but management could not explain us how this was informing the number of staff on shift. Staff on night duty told us they frequently worked with one less worker then needed; we reviewed the rotas for last four weeks and saw some nights there were four staff members on shift but majority there were three staff members. We noted that a considerable number of the falls had happened during the night shift period. The home manager told us they were reviewing the dependency tool and they increased the night staffing levels to four from the day of our second inspection visit.
● Recruitment was not always done safety. The provider was not always completing all the relevant pre-employment checks before allowing staff to start working. The home manager was clear on their responsibilities in relation to safe recruitment and told us they would complete the recruitment of all new staff.

The provider had failed to ensure there were sufficient numbers of suitably qualified staff to ensure people's safety. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The home was not always free of odours. Some communal areas of the home and equipment used by people, such as bath lifts, were not always clean. Records had not been kept of the cleaning tasks completed by staff responsible for domestic duties. On the second day of our inspection, we noted improvement in this area.
● Personal protective equipment such as gloves and aprons were available in several areas of the home. We reviewed the training matrix and found several staff members infection control training was not in date.

Inadequate

Is the service effective?

Our findings

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

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

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care

- People's nutritional and hydration needs were not always met. For example, one person, who had a mental health condition, had been declining to eat for at least two days. There was no evidence staff had taken the time to sit with them and assist them to eat food they enjoyed. This person had lost 4.95 kilos in the past two months. Records showed the last GP visit indicated the monitoring of the person's food and fluid intake had recently been introduced. There was no evidence of discussions with other relevant healthcare professionals. Their nutritional care plan was not detailed.
- During this inspection, we observed one person, who was on the end of life care pathway, was not receiving support with their breakfast and being left with a bowl of cereals on their lap. We noted another person, who was living with dementia, was not allowed to have their breakfast in the lounge and staff said they had to go to designated eating area where their breakfast would be. This person declined to go there and was not supported by staff to have any breakfast. We asked the supporting manager to review people's nutritional care plans without delay and ensure staff were providing the appropriate support. On the second day of our inspection, we confirmed a new nutritional folder had been put in place to ensure staff were aware of people's needs in this area and the home manager told us they were going to review all people's care plans.
- During this inspection, we noted people had lost weight and this had not always been discussed in a timely way with the GP. We discussed these concerns with the supporting manager and deputy manager and on second day of our inspection we confirmed people had been seen by the GP to address concerns with their weight loss; some were prescribed with supplements and referred to a dietician.
- We observed people's dining experience and found the arrangements were not conducive to promote a relaxed and enjoyable environment.
- We received mixed views about the quality of the food. Some people said, "The food, it's always the same fresh vegetables on Sundays, always roast beef, always mashed potatoes or chips." Other people commented, "Food is okay, we can have a choice." During the second day of our inspection, we saw a meeting had been organised with people using the service and their relatives and the home manager told us they would discuss the menu and dining experience.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) and 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● The provider did not always ensure staff had the appropriate skills and knowledge.

● We reviewed staff's training matrix and certificates and found several gaps in training. During our interactions with staff and observation we noted staff's knowledge was not always robust. For example, in relation to safe administration of medication and while supporting people with use of equipment and moving and handling. The supporting manager told us a new online training system had been implemented and staff had not yet been able to complete the training. We saw the provider had made a room available with computers for staff to complete this training. The new home manager said they would be reviewing all staff's training and competencies.

● Staff had not been supported with regular supervision meetings and appraisals to ensure their performance and practice was monitored and supported. We requested but were not provided with any evidence of supervision meetings. The provider did not have an overview of when staff had last had a supervision meeting. The new manager told us they would improve this area without delay.

The provider had failed to ensure staff received appropriate support, training, and professional development, to enable them to carry out the duties they are employed to perform. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service was not ensuring people's capacity to make decisions were assessed when needed and relevant people were involved in making best interest decisions.

● Some people had conditions on their DoLS yet there was no evidence these were being complied with. For example, two people who used the service had as the condition that the provider had to offer regular interaction and activities; there was no evidence this was happening. In our conversations with staff and management, we could not be sure how many people living at the home had a DoLS in place. The home manager told us they were in the process of reviewing this.

● There were blanket restrictions on people. For example, some doors had 2 handles and staff told us this was for people not to access certain areas of the home such as the dining area outside meal times. Staff also told us people "were not allowed" to eat in the lounge areas. We discussed these concerns with the home manager and they told us they were reviewing all these restrictions and taking appropriate actions.

We found the service was not compliant with the requirements of the MCA. This was a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

● The service was not always delivering care in line with current guidance and law. People's protected characteristics under the Equality Act (2010), such as religion and disability were not considered as part of the pre-admission process and we could see no evidence if these were discussed with people after admission or during their stay.
● People did not always have their health conditions sufficiently monitored and plans were not always in place to support people with their health conditions. For example, during our visit a staff member told us a person had lost weight due to dental problems. We reviewed this person's care plan and found no mention of it. They had been referred to a dentist, but the referral had not been followed up. Another person who was known to have hallucinations and seemed to be in distress during the first day of our inspection, had not been referred to the mental health team. We shared these concerns with the safeguarding team and the home manager told us they had taken appropriate action.
● One person had refused their medicine for several days and this had not been escalated to another health professional to check whether this could impact the person's health. There was a lack of guidance for staff to help them recognise when the person needed further support.

Adapting service, design, decoration to meet people's needs
● Some areas of the home needed redecorating. The home manager told us they were going to review the use of carpets in communal areas and were going to discuss redecoration work with the provider.
● The home was not decorated in a dementia friendly way, for example with posters or boxes on people's bedroom doors to help them identify their own rooms. Best practice suggests people find it easier to identify their own room if there are recognisable items to direct them there.
● Some radiators did not have covers on them which put some people at risk of injuring themselves; radiator covers were not fitted to the walls which could increase the risk of falls.

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence

● People's privacy had not always been considered. We noted several people's bedroom doors were left opened but there was no evidence this was people's choice. On two occasions, we had to ask staff to cover people to protect their dignity. We also received mixed feedback from people and relatives about how staff respected their privacy. Comments included, "[Staff] always shout before they come in my room"; "[Staff] Always shut the door when [relative] is on the commode" and "The staff are kind but they don't knock on my door before coming in."

● We saw personal and confidential information about people being left unattended and accessible to others who might not have the right or permission to access it. We asked staff to take action and shared these concerns with the home manager.

● People could not always choose when to have their daily needs met. For example, there was a bath rota that showed people could have a bath once a week. We asked staff if people could have more frequent baths if they wanted to, they commented that if staff had the time they could. One person told us, "When I need the toilet, [staff] say to me 'Do you have to go?', when I want to do a number 2, they say 'I'm busy, you'll have to wait', they know I wear a pad." We spoke with the home manager about these concerns and they told us how they would monitor staff's approach to ensure people's needs were always respected according with their preferences and choices.

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

● People were not always involved in making decisions about their care. We asked people if they had read their care plans or been involved in reviewing them, most people said they had not. Their comments included, "Care plan, no, don't think so"; "Not sure, what's a review?" and "Not now, no meetings about care now." Relatives shared mixed views about being involved in reviewing their loved one's care; "Family are involved in decisions about relative's care" and "Not had any reviews yet."

● We reviewed people's care plans and reviews of care and there was no evidence of people and relatives being involved.

● Some people and relatives told us staff respected people's choices. Their comments included, "I think so, they [staff] listen to me when I say anything" and "[Relative] tells them if something is not how they want it to be. Yes, support is as relative wants."

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

● During this inspection, we observed some positive interactions between people and staff however most staff were very task centred. For example, we observed one person asking staff support to mobilise to use

the toilet; the staff member heard the person calling them and said "wait" and went to get the equipment to help them mobilise. We observed staff assisting a person to have their meal at a pace that was not adequate for them; at the end of the meal the person looked tired. We observed three different staff members attempting to assist another person with their meals, instead of one staff member being consistent in the support; this person did not eat much during this meal.

● People, relatives and visiting healthcare professionals shared mostly positive feedback about staff being caring and kind. People's comments included, "Oh yes, all very kind to me"; "Very kind, care about people" and "All very nice to me." Relatives said, "Definitely kind, we can't fault any of them."

Inadequate

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive person centred care and we found the systems in place did not ensure people received care that always meet their specific needs.
- People's care plans lacked detail in relation to important areas of their care, their preferences and how staff should support them. People's care needs were not regularly reviewed. For example, one person who was living with dementia was known to frequently decline support from staff with their personal care; their care plan did not identify this or how staff should appropriately support this person to maintain their hygiene, skin integrity and dignity. Another person had a mental health condition; their care plan did not show how they would present if they were unwell, how staff should support or when additional medical assistance was required. One person had started living at the service in December 2019; they required support in areas such as their mobility and skin integrity however a full care plan had not been developed and there was only a summary of their needs. We spoke with the home manager about this and they told us they would review all care plans by the end of March 2020 to ensure information was accurate and relevant.
- The home had routines which created an institutionalised environment for people. People had their meals at the same time in the dining area on the first floor; including people with difficulties mobilizing and who had their bedrooms on the other floors. We observed people waiting in the lounge before accessing the dining area and staff supporting them to sit at the tables 20 minutes before the food being served. There was a schedule for people to have a bath once a week.
- People were not offered regular opportunities to interact or be involved in activities. People's comments included, "I like watching telly, don't really have any activities"; "Depending on who's [staff] on, mostly don't bother"; "No activities now, I don't go out much anymore"; "They don't have enough time; I would love to have a run to city centre for a look around" and "I asked them to take me out to buy a writing pad and envelopes, but they said they were too busy." Relatives said, "Last activities organiser used to take [relative] out to the coffee shop next door, [relative] loved that" and "No activities at the moment but they have a singer in."
- Some people chose to stay in their bedrooms or spent most of the time in their bedrooms due to their health and we did not see any evidence of these people being offered regular interaction with staff. We spoke with the home manager about these issues. They told us the activities coordinator had left in December 2019 and a another one had been appointed. The home manager also told us about their plans to consult with people and relatives about activities and ensure staff were involved in activities with people on a daily basis.

We found care was not always designed or delivered in a way that met people's needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● One person living at the home was on the end of life care pathway. We found concerns in relation to how their skin integrity was maintained, their moving and handling support was provided and their nutritional needs met. We did not find any evidence of regular mouth care being provided. This person's end of life care plan was not detailed and did not explore how they wished to be cared for at the end of their life. We shared our concerns with the local safeguarding team and the home manager.

● We reviewed the end of life care plans for other people living at the home and found these were not detailed.

● Staff did not always show a robust understanding of good practice in caring for people at the end of their lives; for example, ensuring the person is pain free, contacts with specialist healthcare professionals is done promptly and mouth care provided regularly. We saw anticipatory medication was available at the service.

We found care was not always designed or delivered in a way that met people's needs and preferences at the end of their lives. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● We reviewed the home's complaints folder and saw no complaints had been recorded since February 2016. Our system indicated two complaints had been raised during 2019. This indicates the systems and procedures in place did not ensure an adequate identification and recording of complaints.

● During this inspection, we did not receive information from people, relatives or healthcare professionals of any complaints raised and they told us they would contact staff or the manager if they had concerns.

This shows the provider did not have effective systems in place to monitor and improve the quality and safety of the services provided, including the records of any complaints or concerns raised. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

● The service had not taken steps to comply with the Accessible Information. For example, we did not see examples of how information had been made available to people in formats that would facilitate their understanding and choice. The home manager told us they were planning to introduce a pictorial menu to support people living with dementia to make choices about their meals.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- At this inspection we found systematic and widespread failings in the management of the service, which meant people did not always receive safe care. There was a significant lack of oversight and monitoring of the service and as a result they had not identified risks relating to people's care, managing medicines, meeting people's nutritional needs, caring for people in a person-centred way, seeking support from other healthcare professionals in a timely way, recruitment, training and supervision of staff.
- The registered manager had not been in the service since August 2019 and their employment ceased in November 2019. The management arrangements put in place by the provider, which included weekly visits by a supporting manager and two deputy managers responsible for the day to day running of the service, had not been effective. We did not see any evidence of how the nominated individual kept an oversight of the management of the service.
- We found the quality assurance processes in place had either not been completed, such as air flow mattresses or staff files, or those completed had not been effective in identifying issues found at this inspection and drive the necessary improvements, such as medication and care plan audits.
- The provider had not ensured records and decisions about people's care were kept secure and were an accurate, complete and contemporaneous record of the care people required and received.
- The provider had not kept appropriate oversight of staff's training and supervision and we found several concerns about staff's practice, knowledge and skills.
- We found not all accidents and incidents were being recorded, for example, behavioural incidents when people had displayed physical aggression towards others, and therefore this information was not being used to inform reviews of care. We found trends from incidents of falls happening at the home where not being analysed to help management review safety aspects of the service, such as staffing levels or staff deployment.

We found the governance systems in place were not operating effectively to ensure people receive safe and consistent care to always meet their needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager told us about their plans to improve the oversight and management of the service, the resources they needed and how they planned to allocate them. We continued in contact with the home

manager and provider for updates on the progress of their actions. The provider had voluntarily placed an embargo on new admissions.

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

● People's care needs were not always being met as detailed in this report and this had an impact on their safety.

● There were mixed views about the culture of the home and the impact it had on people. People's said, "It's nice living here"; "I'm comfortable, we're well fed and we're kept clean and we've comfortable beds"; I am not happy with the standards here, they [staff] are always telling us they're too busy" and "They don't take us out, or let us go out."

● We received mixed feedback from people and relatives in relation to who the manager was and the home's management arrangements. People's comments included, "Don't know who the owner is"; "New manager, think it's a lady. Had a man for two days then he went to another care home" and "I think management here is quite good, I think it has a committee. We don't seem to have any bosses or matrons like they used to." Relatives told us, "Met the owner once, seemed a nice enough man, only spoke to him once" ; "Don't really know [who the manager is] because we've never met anyone" and "Two deputy managers are very approachable, new manager has told us he has an 'open door' policy."

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

● People had not been consulted on their care. On our second inspection day, we saw the home manager was having a meeting with people using the service and relatives however we did not see any evidence this had been a regular practice in the previous months.

● People and relatives told us they had not been invited to complete a survey or questionnaire in relation to their experience of the service or their views on how it could improve. Their comments included, "Never done a survey", "No surveys" and "No questionnaires". However, the provider told us this had been completed in September 2019 and the feedback had been positive.

● We did not find evidence staff had been consulted about the running of the home or changes in management arrangements; some staff members could not tell us who the new manager was. The new home manager told us they were planning to have regular staff meetings.

●There was limited consideration of the equality characteristics relating to the needs of people or staff. For example, the gender preference for people who received care or the specific support people required due to their disability or health condition.

Working in partnership with others

● We saw the home had weekly visits from a GP and district nurses also visited the service on a regular basis. However, during this inspection we saw management and staff had not always sought appropriate medical assistance in a timely way.

● We noted the home had not established partnerships with healthcare professionals specialised in mental health despite several people living at the home were living with dementia and some displayed behaviours which were challenging to others. The new home manager told us they were going to seek support from the local Clinical Commissioning Group in relation to support with management medication and people's health needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care and we found the systems in place did not ensure people received care that always met their specific needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not ensure people's capacity to make decisions is assessed when needed. Conditions on people's DoLS were not being complied with. There were blanket restrictions for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems and processes in place were not operating effectively to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not always appropriately met.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure staff received appropriate support, training, and professional development, to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's medication was not administered safely and people did not always have medication available to meet their needs. Risks to people's care were not managed safely. The environment and equipment was not always safe or clean for people.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were widespread shortfalls in the way the service was managed. Lack of management oversight and accountability.

The enforcement action we took:

Warning notice