Gabriel Court Limited

Gabriel Court Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Gabriel Court Limited is a residential care home for up to 44 older people living with dementia. At the time of inspection there were 40 people living at the home.

People's experience of using this service and what we found
There was a registered manager who had been the manager of the service since it registered with CQC in October 2010.

The provider failed to have adequate systems to assess, monitor and mitigate the risks to people's health, safety and welfare. The provider had not kept up to date with current legislation to keep people safe.

The provider failed to have systems and processes to assess, monitor and improve people's quality and safety of care. They failed to have quality monitoring of all areas to identify where people were not receiving care that met their needs.

The provider failed to have systems to safeguard people from abuse or improper treatment. People were not always treated with dignity and respect.

People, their relatives and representatives had not been involved in the planning of their care. People's feedback and complaints had not been used as learning or used to improve the quality and safety of care.

There were not enough skilled and experienced staff to meet people's needs. Staff were not adequately trained, and their competencies had not been checked. Staff did not receive the support and supervision they required to carry out their roles.

The provider failed to update peoples' risk assessments and care plans regularly or as their needs changed. They failed to have a safe handover system to ensure staff had information about people's current needs.

People did not always receive food and drinks in a safe way or that met their needs. People did not always receive care that had been recommended by health professionals or receive their medicines as prescribed.

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

People had access to indoor and outdoor communal areas. Staff were recruited using safe recruitment practices. Staff understood when to seek medical advice.

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 26 August 2017).

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

Enforcement
We identified nine breaches of regulation in relation to safety of the environment, safeguarding, staffing, nutrition, consent, respect, person centred-care, complaints and governance. 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 always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Gabriel Court Limited

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
The inspection was undertaken by one inspector on 28, 29 and 30 January 2020. Also by an expert by experience on 28 January 2020. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
This inspection took place on 28, 29 and 30 January 2020, the inspection was unannounced.

What we did before the inspection
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. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

We considered our last Care Quality Commission (CQC) inspection report and information that had been

sent to us by other agencies such as commissioners who had a contract with the service. We also contacted Healthwatch. 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 all of this information to plan our inspection. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and four relatives about their experience of the care provided. We made observations of how people were supported, and how staff interacted with them. We spoke with 9 members of staff including the registered manager, deputy manager, five care staff and two catering and domestic staff.

We reviewed a range of records. This included key elements of 11 people's care records, such as mental capacity assessments, risk assessments and daily records and 24 medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider about environmental checks, fire and water safety and safeguarding information. We looked at information relating to the prevention and recording of falls. We used this information to make judgements in this report.

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 deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were at risk of infection from water that had not been managed or stored safely. The provider failed to assess the health and safety of the water supply. The provider failed to follow Department of Health Best Practice Guidance to prevent bacteria such as Legionella in the water supply.
- People were at risk of infection as the provider did not have systems in place to manage an outbreak of illness such as diarrhoea and sickness or suitable cleaning products to manage spillages or deep cleans.

Using medicines safely

- People did not always receive their medicines as prescribed.
- Staff did not always accurately record what they had administered on people's medicine administration records charts.
- People were at risk of harm as staff were using prescribed creams that were out of date and shared between people.
- People prescribed medicines to be taken 'as required' did not have protocols for staff to refer to, to explain when and why they would give these medicines. People were at risk of being given medicines for sedation without a clinical reason, and assessments of the effectiveness could not be measured. We referred the service to the community medicines team.
- Medicine audits were carried out twice a year; this was not often enough to ensure staff followed safe medicines management or that people received all their prescribed medicines.

Assessing risk, safety monitoring and management

- People were at risk of harm as the systems in place to update risk assessments and care plans to reflect their current needs was ineffective.
- People were not sufficiently protected from the risk of falls. One person incurred a serious injury from a fall; their risk assessment had not been updated and staff did not have a management plan to follow.
- Staff did not have enough information about people's needs to know how to keep people safe. The system for handover was not comprehensive which meant agency staff were unaware of all of people's needs and staff were not aware of changes to peoples' needs.
- The provider had not carried out environmental risk assessments. People were at risk of harm from hot surfaces, windows that could open on the first floor and furniture that had not been secured to their walls. People were at risk of accessing items that could cause harm if misused or ingested, as they had access to the kitchen and laundry.
- People were at risk of entrapment in bed rails, between beds and bedrails or climbing over bed rails and falling from a height. The provider had not ensured the bed rails in use were compatible with the beds,

mattresses or pressure relieving mattresses. Staff did not carry out any checks to ensure people were safe in bed with bed rails.
● The provider had not always ensured fire safety procedures had been followed.

The provider had failed to assess the risks to the health and safety of people using the service, or take action to mitigate risks, this is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

After the inspection, we asked the provider to inform us of the steps they had taken to mitigate the risks we had identified:
● The registered manager updated people's risk assessments and implemented new a system of handover.
● The provider employed a specialist to assess the home's water safety.
● The provider updated the fire register and ensured staff and visitors had the code to exit the building through the emergency exits.
● The registered manager had removed bed rails that were not compatible with the beds. Further consideration was required to risk assess and monitor the use of bed rails for each person.
●The registered manager instructed staff to keep laundry and kitchens locked when not in use. The provider arranged for tamper free window restrictors to be fixed to windows on the ground floor and first floor.
● The provider had purchased cleaning products for use at a time of outbreak of illness.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risks of abuse or unsafe care as the provider did not have sufficient systems in place to identify or report all incidents.
● Staff did not always report unexplained bruising or altercations between people using the service to the registered manager. They did not have systems to identify where staff had recorded incidents of potential and actual abuse.
● The provider's safeguarding policy did not correctly guide staff on how to report safeguarding concerns to the local authority; the information was out of date. Staff did not have the information they required to make a safeguarding alert.

The provider failed to protect people from the risks of abuse as they did not have suitable systems to identify and report incidents of physical and verbal abuse. This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

● Following the inspection, the registered manager updated the safeguarding policy to show the current details of the local authority safeguarding team. They reviewed information recorded in people's daily notes and handover information; they reported safeguarding concerns they identified.
● Where safeguarding alerts had been raised the registered manager kept records of these and provided evidence of investigations as requested by the safeguarding team.

Staffing and recruitment
● The provider failed to deploy enough skilled or competent staff to meet people's needs.
● People were at increased risk of falls as the provider failed to ensure there were enough staff deployed to supervise people who had been assessed as at increased risk of falls. Two people had incurred serious head injuries from falls in the week before the inspection. There had been a sharp increase in the number of unwitnessed falls in December 2019 and January 2020.
● People told us they believed there were not enough staff. One person told us, "There are not enough staff

at times, going to the toilet is worse as I go myself and staff are very busy so don't always check to see if I'm okay or need help." A relative told us, "I've been in the activities room where there hasn't been any staff for 15 minutes and I've been on my own with them all. One time one chap sat himself down on the floor but there weren't staff about."

● People were at risk of harm from staff who did not have the skills or competencies to carry out safe moving and handling. Two people had fallen from moving and handling equipment; they had not incurred serious injury. One person described their experience of being dropped, they said, "The night staff was helping me with the [moving equipment] and didn't secure the straps properly and I fell/slid out onto my bottom near the chair. I wasn't hurt and [staff] apologised." The registered manager had not ensured staff were suitably trained or supervised enough to carry out safe moving and handling.

The provider failed to have enough skilled and competent staff deployed to meet people's needs. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

● Training in moving and handling took place during and immediately after the inspection, however, we have not been able to assess the effectiveness.

● Staff were recruited using safe recruitment practices whereby references were checked and their suitability to work with the people who used the service.

Learning lessons when things go wrong

● The provider and registered manager did not have systems in place to identify where things went wrong or have processes to analyse the cause.

● People were at risk of repeated incidents of falls and altercations as there were no systems to establish why this was happening or to implement procedures to stop them happening again.

● The provider did not have sufficient systems to identify where people could be at risk of environmental issues, or processes to take actions to mitigate the risks.

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 deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff had received training, but they had not put their training into practice. The provider had not assured themselves staff had the competencies to carry out their roles." For example, staff did not follow safe moving and handling procedures when using moving and handling equipment, causing two people to be dropped.
- The registered manager had not checked staff were providing care in accordance with their training and policies. For example, when administering medicines leading to medicine errors and failing to ensure people received the assistance they require at mealtimes.
- Staff did not receive regular supervision to support them in their roles. Where supervision had been carried out and poor practice identified, this had not been followed up in a timely way, allowing poor practice to continue.
- New staff did not have supervision in the first 12 weeks; this put people at risk of poor care as their suitability for the role had not been checked.
- New staff's induction did not provide all the information they required, such as how to exit the home in an emergency. Most of the training was done on-line and the provider had not assured themselves that staff applied their learning in practice.

The provider failed to provide the training and supervision required to enable staff to carry out their roles. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

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

- People did not always receive their drink in a safe way. Where people required their drinks to be thickened staff did not always provide this.
- People did not get a choice of meals. We saw every person received the same meal, regardless of their preference or dietary needs. Two people arranged for food to be brought in due to the lack of choice. One person told us, "I don't like the food, friends and family bring me in snacks." Another person said, "I sometimes order delivered food and the staff keep it in their freezer for me."
- People did not get food prepared in a way that met their needs. People who could not manage to cut up their food were at risk of losing weight.
- People were weighed monthly. Where people had lost weight, staff did not provide fortified meals or regular fortified drinks to enhance their diet. Four people had lost significant amount of weight; they had not been referred to the dietitian or GP for advice. One person who had lost weight and required additional food was seen trying to access the biscuit tin but was discouraged by staff.

● Staff did not have all the information they required about people's dietary needs such as allergies. □
● People were not always positioned safely to eat. One person was laid almost flat in their recliner chair whilst staff assisted them to eat. The position put this person at increased risk of choking.

The provider failed to meet people's nutritional and hydration needs. This is a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs

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 were being met.
● There was no system in place to regularly monitor and assess peoples' mental capacity to make decisions about their care.
● Service users did not have mental capacity assessments or best interest decisions recorded for consent to living at the home, medicines, food and drink, bed rails, restrictions to their liberty or constant supervision.
● The registered manager had not assessed people for their ability to make informed choices about their care, they had not made applications for DoLS authorisations to the local authority for people who had restrictions to their liberty.

The provider failed to assess is people have the mental capacity to make informed consent or comply with the Mental Capacity Act 2005 to ensure care and treatment is in people's best interests and legally authorised. This is a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People did not always receive the care recommended by health professionals. For example, one person had been assessed after a fall by health professionals in December 2019; they advised the provider to change the person's bed. At inspection on 28 January 2020, the bed had not been changed. After the inspection, the registered manager arranged for the bed to be ordered.
● People could not be assured the information from health professionals was passed onto staff or carried out. The staff handover system was not comprehensive and information about people's care did not always reflect their current needs. For example, information from hospital discharge letters and nutritional guidance.
● The provider did not have a suitable system for assessing when people required additional supervision and monitoring when transferring to hospital or communicating this information onto emergency services. For example, the registered manager assessed people's need for an escort to hospital on their needs when

they were well, they did not account for the change in people's needs when they were unwell.

The provider had failed to assess the risks to the health and safety of people using the service, or take action to mitigate risks, this is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

● Staff did recognise when people required medical help and contacted the GP and ambulance services appropriately.
● People received regular visits from the chiropodist.

Adapting service, design, decoration to meet people's needs
● People in the high dependency unit had access to a lounge and a dining area. They also had limited access to their bedrooms or the garden as they required close supervision, which was not available to them due to low staffing levels. Ten people spent their whole day in the lounge with no provision for their freedom to walk around safely as the room was small.
● The provider used areas such as bathrooms for storage of equipment, reducing the numbers of bathrooms people could use. The registered manager removed the items stored in the bathrooms immediately after the inspection.
● The provider did not have a plan to refurbish or update the service; the decoration of the home was looking tired and lacked in dementia friendly décor.
● People in the low dependency unit had access to a large communal space and a quiet area and a garden which were suitable for their needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they commenced using the service, however, the information was not a comprehensive enough to have a clear picture of people's needs. For example, one person required medical treatment five days after admission; staff could not provide the ambulance crew with all the information they required as their care plans were sparse.
● Initial assessments did not provide staff with all the information they needed. For example, where people had medical conditions which affected their daily living such as loss of sight, this was missing from the care plans.
● People's records showed aspects of a person's needs were considered including the characteristics identified under the Equality Act and other equality needs such as peoples religious and cultural needs. Care plans included people's preferences such as the gender of staff providing personal care, which staff were aware of.
● Staff used risk assessment tools to assess people's risks.

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 deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
● People were not always treated with respect. One person was unhappy with the way they were spoken to, they said, "A little more respect for us is needed as sometimes they treat us as if we are senile."
● Staff were seen discussing their next task and other people requiring care whilst assisting a person to mobilise.
● Staff walked into people's rooms uninvited when they were receiving treatment from health professionals.
● One member of staff spoke to people in one-word sentences. For example, they said "Table. Table." Many times, getting louder each time, to indicate a person was to walk to the dining area for lunch. When the person realised this was what the member of staff meant, another member of staff ridiculed them for taking so long. Both members of staff did not engage with the person to ensure they knew they were having a conversation or talk to them in a kind way.
● We saw people trying to engage with staff who did not always acknowledge them. When staff did acknowledge them, they called across the room to them, and did not talk to them in a respectful way.
● Staff were seen shouting to each other up the stairs discussing equipment needed for personal care.

The provider failed to treat people with dignity and respect at all times. This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect

● Some people were happy with the way staff cared for them. Most people told us staff were kind, one person said, "The staff here are very caring, they help me in any way they can, they help me get to bed, go to the toilet and check on me at night. I think they are lovely." Others told us, "The staff are nice and caring", "When they are showering me, they are gentle and check me over." and "The care staff here are nice, I have a laugh with them."
● Some people told us they were unhappy that staff did not have time to spend with them. Two people said staff were very busy. They told us, "I think the care staff especially one of them rushes things. I hear them bump the door as they come in and as I can do quite a few things for myself sometimes feel a bit rushed." and "One carer always seems to be in a bit of a rush."
● The registered manager told us they involved church groups so people to practice their faiths. However, not all people were aware of this. One person told us, "They don't have any church services here. It would be nice to have communion here sometimes."

Supporting people to express their views and be involved in making decisions about their care
● People in the low dependency unit chose where they spent their time. For example, in their rooms or in

the communal or quiet lounge. One person told us, "I choose to have my bedroom door closed all the time and they [staff] respect that."

● People had been asked to feedback about their care in August 2019, where they had complained about staffing levels and the choice of menu. Both staffing levels and choice of food continued to be an issue.

● People could had access to an advocacy service. Advocates are independent of the service and support people to decide what they want and communicate their wishes.

Respecting and promoting people's privacy, dignity and independence

● People based in the low dependency unit were able to access the garden independently. One person visited the shops independently.

● Staff encouraged people to maintain their mobility. One person told us, "[Staff] encourages and helps me with my walking. I try to challenge myself each day. [Staff] will stand by me when I do some steps and is very encouraging."

● People's information was stored securely within the office, and all staff were aware of keeping people's personal information secure.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- People's care plans did not always reflect their current needs, they had not been regularly updated.
- People had not been involved in their care planning. One person's representative told us, "I always said I was available and to contact me about [Name's] care, but they never did, I was never involved." One person told us, "I haven't been asked about my likes and dislikes."
- Staff did not put people first. Staff worked through tasks to complete people's care at set times that fitted staff routine and not to meet people's needs or preferences. People in the high dependency unit were washed and dressed and given breakfast early in the morning by night staff. There was no indication that people preferred to get up early or had chosen to do so.
- People in the high dependency unit remained in one lounge all day. Staff did not provide any interaction or pastime for long periods, especially in the afternoon. Staff spent their time asking people to sit down whilst they wrote their notes and swapped with each other to attend to other people in their rooms who required personal care.
- Staff told us they had items designed to occupy people living with dementia in the drawers, but these remained in the drawers and not made available for people to use in the high dependency unit.
- People told us they were unhappy with the activities provided, one person described them as childish. Another person said, "There are no activities, I stay in my room, they don't do one to one activity here, my family come and play cards with me and I watch TV."

The provider failed to ensure all people received care that met their needs and preferences. This is a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care

- Activities staff were employed to provide time with people, one had recently started. There were resources for people in the low dependency unit to take part in crafts and games. People in the high dependency unit had activities such as crafts in the mornings.
- People in the high dependency unit had received chair exercises once a month in 2019 from an external company, and a singer had visited the home in September 2019. They also received visits from the school and had visited the school for a coffee morning.
- People celebrated events such as Christmas and there had been a summer fete.
- People's visitors were welcomed during the day; they were asked to avoid meal times to help people concentrate on their meals.

Improving care quality in response to complaints or concerns

● The registered manager did not always follow the provider's complaints procedure. We had received information via safeguarding, whistleblowing and relatives which showed complaints had been raised with the registered manager. The registered manager told us there had been no complaints made.

● People told us they knew how to make a complaint, they had raised their concerns verbally with the registered manager who had responded quickly. One person said, "They [registered manager] don't mind me telling them if there are any problems, I told [deputy manager] that someone's food had been taken away before they had finished, [deputy manager] took it on board." However, this and other complaints had not been recorded.

The provider failed to have a system to record and respond to complaints. This is a breach of Regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints

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 registered manager had not explored ways to assist people living with advanced dementia to understand their care.

● People did had information in easy read and picture form to understand what their choices were, for example choice of menu or where to spend their time. However, these were not always used.

● Staff ensured people wore their hearing aids and glasses, so they could communicate the best they could.

End of life care and support

● People and their representatives were given the opportunity to record what was important to them at end of life, such as where to receive their care. People's wishes were followed.

● Staff liaised with health professionals to ensure people were assessed for their symptoms and kept comfortable.

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 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; continuous learning and improving care

●The provider had failed to have systems to assess and monitor the safety of the home, placing people at risk of injury, infection and harm.
● The provider failed to have systems in place to assess, monitor and improve the quality of the service. The measures in place to maintain oversight of staffing levels, staff training, staff competencies, risk assessments, care plans, daily notes, handover, falls, the environment, water safety or fire safety were ineffective.
● The provider failed to monitor the accuracy and completeness of records. The night staff recorded all people received their care at 11pm, 2am and 5am, regardless of when they had actually provided the care. The staff daily notes and handover were not complete and did not provide staff with the information about peoples' current needs.
● The provider failed to have systems to assess and monitor care and records to identify safeguarding issues and staff compliance with safeguarding procedures.
● The provider failed to have a system to check whether their policies for infection prevention were fit for purpose, in line with legislation and followed by staff.
● The provider failed to have a system to update theirs or the registered manager's knowledge and competencies to manage the governance systems of the home.
● The provider failed to have systems to monitor people's mental capacity to make decisions or make Deprivation of Liberty (DoLS) applications.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider and registered manager did not promote a person-centred culture within the home. The provider failed to have systems to enable people or their relatives to regularly review peoples care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and registered manager did not have any system to inform and meet with people and their relatives to discuss the reasons and impact of falls and poor moving and handling practice had on people's physical and mental well-being. The provider failed to understand their duty of candour.
● The provider and registered manager did not have systems to support staff to learn from incidents.

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

● Regular meetings took place for staff, however, the discussions that took place during these meetings had not resulted in the improvements to the safety and quality of care.

● The provider had gathered people's views of the service in the form of a survey. People had raised concerns about staff not having time to meet their needs; the provider failed to address people's concerns as staffing had not been improved and people continued to not have their needs met.

The provider failed to have systems and processes in place to assess, monitor and mitigate the risks relating to health, safety and welfare of service users, or have systems to improve the quality and safety of care. This is a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Working in partnership with others

● Representatives from the local authority quality team had conducted monitoring visits and identified concerns with the service. The registered manager was working with the local authority to make the improvements needed.

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 The provider failed to ensure all people received care that met their needs and preferences.

The enforcement action we took:

We imposed conditions on the provider's registration.

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

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to assess is people have the mental capacity to make informed consent or comply with the Mental Capacity Act 2005 to ensure care and treatment is in people's best interests and legally authorised.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of people using the service, or take action to mitigate risks.

The enforcement action we took:

We imposed conditions on the provider's registration.

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 provider failed to protect people from the risks of abuse as they did not have suitable systems to identify and report incidents of physical and verbal abuse.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to meet people's nutritional and hydration needs.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to have a system to record and respond to complaints.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems and processes in place to assess, monitor and mitigate the risks relating to health, safety and welfare of service users, or have systems to improve the quality and safety of care.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to have enough skilled and competent staff deployed to meet people's needs.

The enforcement action we took:

We imposed conditions on the provider's registration.