Wellbeing Care Limited

St Georges Care Home

Inspection report

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Date of inspection visit:
27 April 2022
05 May 2022

Date of publication:
03 August 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Georges Care Service is a residential care service providing accommodation and personal care to up to 35 people aged 65 and over. Most people were living with dementia. At the time of the inspection there were 24 people living in the service.

People's experience of using this service and what we found

Risks to people were not always recognised and mitigated. Medicines were not managed safely. There were not enough staff on duty to ensure people's care and support needs were being met. Appropriate checks were not always conducted prior to staff working at the service.

Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from the risk of abuse and improper treatment. Staff were not deployed effectively to ensure care was delivered in a safe way. Although large parts of the service were clean and well-maintained staff were not always following good infection prevention control as they frequently removed their mask/face covering in the vicinity of people living at the service.

Safeguarding and accident and incident records were inaccurate and incomplete, which impacted on the provider's ability to analyse information and to learn when things went wrong.

People continued to not always be safeguarded from the risk of abuse as oversight of these systems were not effective and the provider failed to take action when required.

The provider was not working in line with the principles of the Mental Capacity Act 2005. 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.

We were not assured the provider or manager understood regulatory requirements. The provider and registered manager had not notified CQC of all potential incidents and safeguarding concerns at the service. There was a lack of effective and robust quality assurance tools and oversight in place at the service.

The service had received support and guidance from the Local Authority and Clinical Commissioning Group (CCG) and there was an action plan in place. However, insufficient improvements had been made or sustained despite the additional support.

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

Rating at last inspection and update

The last rating for this service was Inadequate (published 20 September 2021). The service remains rated Inadequate. This service has been rated either Requires Improvement or Inadequate with breaches of the regulations for the last six consecutive inspections both under the previous provider and this provider.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care service inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see all of the key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'St Georges Care Home".

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staffing, risk management, person centred care, the application of the Mental Capacity Act 2005, notifications and 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

St Georges 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and a medicines inspector who specifically looked at the safe management of people's medicines. Following our visit on site an Expert by Experience made telephone calls to people and their relatives to seek their feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
St Georges Care Service is a 'care service'. People in care services receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Georges Care Service is a care service without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post however the registered manager was also the regional manager and therefore was overseeing some of the providers other care services as well. The registered manager was also the CQC nominated individual for the provider. The nominated individual

is responsible for supervising the management of the service on behalf of the provider. We have referred to this person as the 'registered manager' in this report.

There was a manager in post at St Georges Care Home who commenced employment in early 2022. This manager was in the process of applying to CQC to register and take over the registered managers position from the regional manager. We have referred to this person as the manager in this report.

Notice of inspection
This inspection was unannounced on both days.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return (PIR) prior to this inspection. The PIR is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with relatives of eight people who used the service about their experience of their family members care provided. We also had contact with ten members of staff, including the manager and the registered manager.

We observed people's care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included people's care records and medication records. We looked at a variety of records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection we found risks were not adequately assessed. We had widespread concerns about the management of risk and the lack of guidance for staff to keep people safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns and the provider was still in breach of Regulation 12.

- Some relatives raised concerns about their family members safety at the service. One relative said, "I don't think that [family member] is 100% safe, some [people] wander into [family member's] room, [the care service] don't do anything about it." Another person's relative commented, "[Family member] has a pressure mat by [family member's] bed and many times it is disconnected. We have heard the mat go off in the room and they leave it up to 30 mins before they turn it off, and no one came to the room."
- Management of risk continued to be inadequate. Risks to people's safety and welfare were not being assessed, mitigated or managed effectively in order to keep people safe.
- Some people either already had or were at risk of developing a pressure ulcer. There were inconsistencies in the care records. For example, for one person their care plan stated they should be repositioned at specified times during the day and at night to help reduce the risk of further skin damage and to promote healing. This guidance was not being followed by staff and there were multiple gaps in the records.
- Records of staff supporting some people to reposition to reduce the risks of pressure ulcers worsening or developing did not evidence that those people were supported in line with their care plans. This placed people at risk of harm.
- Several people had been involved in a number of situations of distress that presented a risk of harm to themselves or others. Some staff told us the training they had received did not equip them with the skills required to manage risks associated with supporting people in these situations safely.
- There was a lack of effective systems in place to ensure that concerns were reported and fully investigated in a timely manner. We found that whilst staff had completed incident reports when they found unexplained marks or bruises on a person's body, records did not demonstrate what follow up actions were taken to investigate this and to try and prevent a re-occurrence. Lessons were not learned where things went wrong, and we found multiple examples of accidents and incidents where no action had been taken to reduce future risk to people.

The provider failed to have robust systems to assess and mitigate the risks to people. This placed people at risk of harm. This was a repeat breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to people's medicines not being managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns and the provider was still in breach of regulation 12.

- People's medicines were not always managed and administered safely to ensure they were not placed at risk.
- People did not always receive their medicines in line with prescriber's instructions. For example, one person who required time critical medicines for their Parkinson's Disease had received this late on three occasions in the past month.
- Medicines prescribed for external application such as creams and emollients were not being kept sufficiently safe to ensure people could not access them and put themselves at risk of accidental harm. Whilst no one had been harmed, there was the potential for this to happen.
- We looked at the electronic Medicine Administration Record system and found that for some medicines there were discrepancies where the recording system did not show and confirm they were given to people as prescribed.
- There were inconsistencies in the written guidance available to help staff give them their medicine prescribed on a when required basis (PRN) and for some people their guidance held insufficient person-centred detail to enable staff to give people their medicines consistently and appropriately.
- There were gaps in records about both the removal of prescribed medical patches and the sites of application of the patches to the person's body. We also noted that there had not been appropriate intervals of time before repeating the site of application to avoid the potential for irritant skin reactions.

Systems were either not in place or robust enough to demonstrate safety in the management and administration of medication. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient staff deployed to ensure people received their care in a timely manner and that their safety was monitored. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns and the provider was still in breach of Regulation 18.

- We received feedback from relatives that there continued to be insufficient staff to ensure their family member received their care a timely manner. One relative commented, "There are not a lot of staff, sometimes at evenings there is not enough staff." Another relative said, "[Family member] has a call bell and staff sometimes take a long to come; it depends on staffing at the time." A third relative said, "I've noticed that there is not enough staff, when we visit at weekends you don't see many staff about."
- Our observations were that the deployment of staff was insufficient at times, particularly over the lunch time period. Staff were busy and at times task focussed with a lack of teamwork across all departments within the service which resulted in some people becoming distressed at times. The provider had a dependency tool in place however this was not being used correctly and therefore was not effective in determining the correct levels of staff required on each shift.
- People were not always protected by robust recruitment procedures. The provider could not assure themselves that at the point of safe recruitment pre-employment checks were completed. Not all staff had a

Disclosure and Barring Service (DBS) check prior to them working alone and supporting people with their care. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The shortfalls in the recruitment and selection of staff had increased the risk people might not always receive care from trustworthy members of staff.

● Not all staff had received training relevant to their role. This included nutrition and hydration and working with people who may have displayed anxiety or aggression towards themselves or other people and/or staff." The provider told us that the COVID-19 pandemic and their transition to an eLearning system had impacted the delivery of training.

Staffing levels, staff deployment and recruitment processes were insufficient. This put people at risk of harm. This was a continued breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse and harm. Not all safeguarding concerns had been discussed with, or referred to, the Local Authority Safeguarding Team. This meant there was not always independent oversight to ensure people were fully protected.

● Several staff told us there was often a difficult atmosphere at the service, one where they didn't feel able to speak up or report concerns for fear of repercussions. This did not assure us that staff felt able to raise concerns, to keep people safe, in an open culture.

● Staff received training in safeguarding and were able to tell us the action they would take should they have had a safeguarding concern. However, we found that staff were not always reporting their concerns which put people at risk of harm.

Systems and processes were not established and operated effectively to prevent abuse of service users or investigate concerns. This was a breach of regulation 13 (1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured staff were using and disposing of personal protective equipment (PPE) effectively and safely. We observed staff not wearing masks or wearing these incorrectly, for example under their chin.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some damaged flooring that was hard to clean was replaced promptly after we highlighted it.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

The provider was facilitating visits to people living at the service in accordance with current guidance.

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 our last comprehensive inspection (published 18 November 2020) we rated this key question Good. At this inspection the rating has deteriorated to Inadequate. This meant the effectiveness of people's care, treatment and support did not achieve good outcomes and was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 services, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff did not always work within the principles of the MCA. We heard examples of staff describing care provided to people, as they went about their job role, that wasn't in line with the legal framework and wasn't in line with promoting people's right to make choices.
- Information available about how some people needed to have their medicines needed further detail. Staff told us differing accounts of which people could have their medicines given to them concealed in food or drink (covertly) when they were unable to consent to taking their medicines and would otherwise refuse them. We also found that for some people liable to have their medicines given in this way there was a lack of records showing that the service had formed best interest decisions about this by consultation with appropriate persons.
- MCA assessments were available within people's care records, however, they did not all include aspects of people's care such as how staff were to respond to people who may have refused care.

Failure to work under the Mental Capacity Act is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff training was not up to date in all cases. There were some gaps in the skills and knowledge of staff

across areas of the service such as fire safety, moving and assistance and positive behaviour support. A member of staff commented, "We have staff who have been working here a while who need re-training. Some staff don't use great language and they forget it's someone's home."

● The staff who cared for people who displayed anxiety and aggression at times did not always have the experience or training they needed to manage and reduce these behaviours effectively. People could not be assured that all the staff would have the skills to meet their needs and keep them safe.

● Most staff told us they felt supported in their job roles and that they received good support from the manager and that the training they were provided with met their needs. Some staff, however, spoke of training being cancelled at short notice which they found frustrating.

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

● The dining experience we observed was disjointed and disorganised which resulted in some people sitting at the dining table waiting for their food and drink to be served for over an hour. This resulted in some people being restless and repeatedly leaving the table and others becoming verbally unsettled.

● People that were nutritionally at risk were not always monitored through frequent recording of their weights. Some records were contradictory and weight monitoring was not consistently undertaken in line with the persons care plan.

● People's relatives spoke of the good choice of meals their family member had at the service. One person's relative told us, "[Family member] has put on weight here, they like the food." Another relative said, "The food always looks good, and they have a good choice, I see it on [family member's online care plan notes]." A third relative commented, "[Family member] has enough to eat and drink and can have a drink and snack when they would like."

We recommend the provider carries out their own mealtime experience audits to identify areas of good practice and whether further learning is needed to ensure a pleasant and well organised meal for people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were not always being supported in a way which led to good outcomes for their care and support.

● Healthcare guidance had also not been consistently followed. For example, in relation to the required support to reduce the risk of pressure ulcers or the administration of prescribed medicines.

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

● The premises were accessible and suitable for the needs of the people living there, with aids and adaptations available to assist people where needed.

● The provider was responsive to any repairs needed. On the first day of our inspection visit we noted damage to a communal bathroom floor and side of the bath which we reported to the registered manager. On the second day of our inspection this area was being refurbished.

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

● The provider had not completed any new assessments in the past year as there had been no admissions into the home.

● Records from previous admissions demonstrated that standardised assessments were used to identify dependency and risk, and care plans were formulated as a result.

Inadequate

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 our last inspection we rated this key question Inadequate. At this inspection the rating has remained Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

At our last inspection there were systemic failings. People living at the service did not benefit from a caring culture. This was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection insufficient improvements had been made and the provider was still in breach of Regulation 10.

● Due to the concerns identified during this inspection, we could not be assured that people received high quality, compassionate and caring service. We have taken these concerns into account when rating this key question.
● Whilst the staff were intuitively kind and caring people, they failed to identify shortfalls in their own practice which compromised the dignity and respect of those they cared for. This meant that staff did not always deliver care to people that was consistently kind and caring.
● People were not always well-supported with regards to their specific care and health needs and risks to their health and safety. This was not respectful of their equality and diversity. One person's relative told us, "I don't think that the personal hygiene is very good, [family member] more often than not has food spillage on their clothes."
● People did not always receive support with adequate oral hygiene. Records of people's oral care contained multiple gaps. For example, during April 2022, one person had a record of oral care being provided on only 11 days. A member of staff told us, "Oral care is not as good as we would like. Other care staff don't clean people's teeth to be honest." This did not uphold people's dignity and was not caring.
● Processes were not always followed correctly to ensure people's rights were upheld and their capacity to make their own decisions considered and supported. This meant people were on occasions delivered care they had refused to consent to, which was not caring.
● As per the 'Safe' section of this report, appropriate action was not always taken by staff where people had unexplained injuries and the causes of these injuries were not always investigated. This meant that the service could not identify potential abuse. The management of the service had failed to identify staff were not following the service's policy and placing people at risk.
● Whilst staff were caring people and made positive comments about the current manager, people told us that a culture of caring was not practiced and encouraged by senior management staff. This meant staff felt unable to be open, honest and transparent about concerns for fear of repercussions. Staff and external health professionals told us of occasions when staff had been disciplined in public areas of the service in an

'disrespectful manner'. This was not conducive to a kind, caring and inclusive atmosphere.

Poor systems to ensure people's rights were upheld and a lack of dignified and respectful care were a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff speaking with people with affection and treating them with dignity and respect. We received mixed feedback from relatives about the care their family member received. One relative said, "The majority of staff are really caring and listen although sometimes they have to be reminded of our requests. I do feel that [family member] is cared for, some staff are more caring than others." Another relative commented, "They treat mum with care, respect and dignity."
● People were supported to maintain their privacy. For example, staff closed doors and curtains whilst providing personal care.
● People's care records were electronic and password-protected to restrict access to these to the authorised persons.

Supporting people to express their views and be involved in making decisions about their care
● Staff showed patience and gave people time to answer questions about the support they wanted. A relative told us, "The things that they do well is that they do care, and I do think that they try to get to know [people]. They also treat them with dignity, respect even to the residents who cannot communicate well."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating has been rated 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; 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's individual communication needs were included in their assessments and care plans, so staff were aware of any specific support needs.
- Care plans were in place for each person. These were detailed in some areas but in others further information was required to make them person centred. For example, one person had a dementia care plan which stated what the signs and symptoms of dementia were, and that the person had limited facial expressions but didn't state what those were, or could mean for that person.
- Staff were employed to specifically support people to take part in activities and their hobbies.
- We received mixed feedback about the opportunities available to participate in hobbies and activities of interest. A relative told us, "[Family member] gets bored, I do make suggestions of activities which can be done. I told them that [family member] would like to go for walks, even in the garden. [Family member} loved to walk before they went to live in the care home." Another relative said, "It would be good if someone took them into the garden to help tidy up and plant things."
- All of the staff we spoke with told us the activities and engagement opportunities available to people needed to be improved and some staff told us the activities taking place during the first day of our inspection were for the benefit of the inspection team and not what ordinarily occurred. A member of staff told us, "CQC turned up and all of these activities were going on. It shouldn't be like that, seeing lots of [activities] going on today and tomorrow people will be sitting there miserable again."
- The registered manager told us they had already identified improvements were needed to the activities and opportunities for people to partake in their hobbies and that a new and refreshed activities plan was being developed as well as the recruitment of a second activities co-ordinator for the service.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carer's, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were identified, and their preferred methods recorded in their care plans.
- Information about the service was provided in alternative formats such as easy read and large print where required to make it easier for people to access, read and understand.

Improving care quality in response to complaints or concerns

● The registered manager told us they maintained a complaints log and gave us an example of how they had dealt with a recent complaint.

● Several people's relatives told us they were confident complaints would be dealt with should they have any. One relative said, "I have no concerns or complaints; I am sure that they would be dealt with if I did have any." Another relative commented, "I have no concerns, but I did have to make a complaint verbally and it was dealt with."

End of life care and support

● At the time of our inspection, no one living at the service was receiving active end-of-life care.

● Some people had end of life care plans in place however people and their relatives wishes not to discuss arrangements were also respected.

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 our last inspection we rated this key question Inadequate. At this inspection the rating has remained 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last two inspections we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a lack of robust oversight of the service. We found similar concerns at this inspection in addition to identifying other repeat breaches of regulation. The provider remains in breach of Regulation 17.

● The provider had failed to ensure the service made the necessary improvements following the last two inspections and having been placed in special measures following the most recent inspection. The service has a history of failing to provide a good standard of safe care.
● People were at risk of receiving unsafe, poor quality and inadequate care and support. At this inspection we found the provider to be in breach of six of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; 10, 11, 12, 13, 17 and 18 and one breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Act. This meant we had multiple concerns across the service. Three of these breaches were repeat breaches - standards had not improved since our last inspection visit.
● Quality assurance systems were not robust. There continued to be a failure to manage risks posed to the health, welfare and safety of people. This included safe administration of medicines, safeguarding and risk management.
● The service continued to operate a culture that exposed people to the risk of harm as safeguarding concerns were still not always reported and investigated fully.
● There had been a high number of management changes which had destabilised the service and resulted in inconsistency in approach.
● Not all relatives were complimentary about the management arrangements or frequent management changes at the service. One person's relative said, "I know who the manager is, the problem is that there have been so many managers over the years. There is no continuity. Why can't they keep the managers?" Another person's relative commented, "The communication is really poor, I don't know if the current manager is the manager or not. I don't get replies to my emails, they just don't get back." A third relative told us, "Relatives meetings don't achieve much, they [managers] sometimes follow things up, but it tends to be the same things over and over again." A fourth relative said, "I have filled in online questionnaires, and nothing has changed [as a result]."

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

At our last inspection the provider had failed to submit notifications about events such as safeguarding incidents to CQC. This failure to notify as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found continued concerns and the provider was still in breach of Regulation 18.

- The service operated a culture that exposed people to the risk of harm as safeguarding concerns were not always reported and investigated fully.
- Safeguarding notifications had still not consistently been submitted to CQC as required by law. People and staff had been physically assaulted, but these incidents were still not being reported to CQC.

This continued failure to notify as required was a repeat breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Working in partnership with others

- The service worked with key organisations, such as the GP's and community nursing and healthcare teams. A healthcare professional told us, "[Manager] I will specifically say is a polite, knowledgeable and supportive individual who works extremely hard for the betterment of the service and [people]."

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 18 Registration Regulations 2009 Notifications of other incidents Not all notifications were submitted to CQC as required by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not always respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured consent to care was obtained in line with relevant legislation and guidance.

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 Systems and processes were not established and operated effectively to prevent abuse of service users or investigate concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to keep people safe. Not all staff had the knowledge and skills

required to support people safely.