Centenary Care Homes Limited

Centenary House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Centenary House is a residential care home and was providing personal care to nine people aged 65 and over at the time of the inspection. The service can support up to 13 people. All bedrooms are on the ground floor and there is access to a communal lounge and conservatory.

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

People we spoke with were unable to provide us with detailed explanations of life at the home.

There were widespread and systemic failings identified during the inspection. The quality and safety monitoring systems used by the provider were not fully effective in ensuring the quality of service provision and that people were protected from avoidable harm.

The provider had failed to make appropriate statutory notifications; safeguarding incidents had not been identified and reported. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been managed.

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 systems in the service did not support this practice.

At the time of inspection there was no registered manager in place. There were also not enough suitably qualified staff to ensure people received safe and effective care. People did not receive adequate levels of personal care and were seen to be unkempt.

Care plans did not contain sufficient information to ensure people received person centred care. The guidance within peoples' risk assessments was not always followed by staff and records used to monitor peoples' health were not always completed. This exposed people to risks of neglect and unsafe or inappropriate care or treatment.

People had access to healthcare professionals however, the provider could not be assured staff would be able to identify when referrals were required as associated documents were incomplete.

Procedures for the administration and the disposal of medicines had not been completed as required. Medicine errors were not recorded and audited.

The environment including the kitchen, laundry and people's bedrooms were unclean and not maintained effectively; there was an infection control risk to people using the service. Fire risk had not been appropriately managed and access to the communal environments for people in wheelchairs had not been

considered.

People did not receive a balanced and nutritious diet, there was little access to fruit and vegetables.

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 requires improvement (published 8 January 2020). This service has been rated requires improvement for the last seven consecutive inspections. The service has now further deteriorated to inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, medicines and poor diet. A decision was made for us to inspect and examine those risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Centenary House on our website at www.cqc.org.uk.

Enforcement
We have identified eight breaches in relation to staffing, consent, safeguarding, risk assessments, care planning and activities, governance, dignity and respect and recruitment at this inspection.

Following the inspection, we placed a restriction on the provider's registration to prevent them from admitting people to the service

Follow up
Shortly after the inspection, the provider put in an application to close the service, which was processed by the CQC; the home was closed and is no longer registered with the CQC. The local authority assisted in moving people to other suitable services.

Special Measures
The overall rating for this service is 'Inadequate' and the service was put into 'special measures' post inspection. This usually 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. However the provider made the decision to close the service shortly after the inspection.

Usually 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.	**Requires Improvement**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
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. The findings are in our well led findings below.	**Inadequate**

Centenary House

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
Two inspectors carried out the inspection over one day.

Service and service type
Centenary House 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. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There had been no on-site managerial cover since at least mid-February 2020.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection in November 2019. This included details about incidents the provider must notify us about. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our 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.

During the inspection
We spoke with seven people who used the service and two relatives about their experience of the care provided. The majority of people we spoke with could not provide us with detailed information. We spoke with three members of staff including the deputy manager, care workers and the chef.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at one staff file in relation to recruitment; this was because only one person had been recruited since the last inspection. We looked at three staff files in relation to staff supervision and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with local authority professionals who visited 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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

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

Staffing

- There were not sufficient numbers of suitably qualified and experienced staff to meet people's needs. The service did not use a dependency assessment tool or have any system in place to ensure staff level deployment was safe and met people's needs.
- On the day of inspection there were two care staff on duty between 8am to 10pm. The deputy manager was present but was office based and not involved in providing care to people.
- There were nine people, three of whom were cared for in bed and at least four of the nine people required two staff to assist them with repositioning, personal care or moving with a hoist. This meant that when one person who required two staff to assist them was being assisted, there were no other staff available to support the other people.
- The care staff were required to prepare people's meals and carry out cleaning and laundry tasks. The cook and cleaner worked part time. This meant that sufficient care staff would not be available to meet people's care needs.
- In the week commencing 09/03/20 the cook was off on three days and their duties were not covered by a replacement. In addition, the cleaner worked for two and half hours on the Monday and two and a half hours on the Wednesday; a total of five hours for the whole week with no cleaning hours rostered from Wednesday afternoon until the following week. In the hours where the cook and cleaning staff were not working their roles fell upon the two care staff on duty. This level of staffing did not demonstrate a sufficiently staffed service
- During the night there was one waking night staff on duty and one sleeping staff member. The level of staffing did not consider the re-positioning needs of people or the requirements to evacuate the premises quickly in the event of fire.
- When people expressed a gender preference in relation to the staff who would be providing personal care, there were occasions when these could not be met. This included when people required support from two care staff for personal care.
- Staff worked excessive hours to cover staff absence and shortfalls. For example, on one day a member of staff worked from 15:00 to 06:00 the next day to cover sickness.
- There were long periods during the inspection when no staff were visible in the building and this did impact on people having to wait for hot drinks. At one point, one person walked into the office where we were working and asked one of the inspectors if they could please make them a cup of coffee. The inspector could not find a member of staff and had to wait for one to return before this could be arranged.

People were supported by staff that were not sufficient in number to meet their needs. This was a breach of

Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely;

● Although there were risk assessments in place for some aspects of people's care, this was not consistent in all the plans we looked at. For example, we looked at the plan for one person who was bedbound and at increased risk of skin breakdown. No risk assessment had been carried out and there was no plan in place to inform staff how to reduce the risk of pressure ulcers developing. The guidance within the plan was limited to, 'Check [they] are comfortable in bed.'

● Daily care logs had not always been filled in and therefore did not indicate that people were supported to move as often as they should be. In one person's care log there were no recorded position changes for a 24-hour period. In another person's plan, the guidance for staff was, 'Two hourly repositioning and four hourly during the night.' The care logs for this person showed this had not taken place as required. On more than one occasion the person had not been re-positioned at all during the night. This meant there was an increased risk of skin breakdown because care plan guidance was not being followed. We found that people who required re-positioning had pressure damage that was being treated by district nurses.
Staff told us that they had been informed re-positioning was not required at night, but there was no record of this instruction..

● People were at risk of choking. Risks in relation to nutrition and choking had not always been assessed or documented. In one person's plan it was written that food should be pureed to a thick consistency using prescribed thickener and to follow instructions from SALT (Speech and language therapy team). Records showed that staff were adding different amounts of thickener. This meant the risks of people choking from having the wrong consistency of food or drinks, was higher than it should be. There was no risk assessment or guidance for staff where one person's plan stated they enjoyed eating a particular high risk food.

● People had been assessed for the risks associated with mobility. However, care plans did not always contain the most up to date information. One person had previously shown signs of aggression towards staff. Although the plan provided information for staff on how to de-escalate the situation, there was reference made to the person's walking aid, which they no longer used. This meant the plan was inaccurate.

● Records were kept of regular health and safety checks. However, action plans relating to such checks were not always complete. For example, the fire risk assessment completed in June 2019 had actions outstanding that were required to ensure the compliance of the fire doors in the service. There had been no checks on fire doors other than those undertaken by an external contractor over six months previous to the inspection.

● Electrical fire risk was not managed. We saw an extension lead plugged into another extension lead both with several appliances plugged into them. We also saw an extension lead which was hanging from a height and creating a pull on the lead; these were both fire hazards and had not been identified by the provider.

● Radiators were uncovered in some bathrooms putting people at risk of burns. The related risk assessment did not mitigate the risks or follow Health and Safety Executive guidance.

● Medicines were not always managed safely. Handwritten changes made to medicine administration records (MAR) had not been checked and countersigned by another member of staff. This meant there was a risk that the medicine instructions had been transcribed incorrectly. Additionally, the handwritten changes did not include information about the strength of medicine or the maximum recommended dose.

● There were no records of medicine errors or near misses being reported. During the inspection a pot of tablets was found in the trolley. It was identified that these had been dispensed for one person who was unable to take them at the time. The staff member had put them back in the trolley but had not prepared them for disposal.

● Some people had been prescribed topical creams and lotions. We saw that creams and lotions had not always been dated when opened. This meant staff would have no way of knowing when creams and lotions had expired and needed to be discarded.

● There was no British National Formulary (BNF) guidance or up to date alternative means for staff to access

information about the medicines they were administering. The only reference book we saw was The British Medical Association guide to medicines and drugs published date 1990.

People were not safe because the provider was not managing and mitigating risks to people effectively, including those relating to medicine management. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines were stored safely. The temperature of the medicine's fridge and the area where the medicines trolley was stored was monitored.

Preventing and controlling infection

- The service was unclean throughout, including service users' bedrooms, the kitchen and the laundry.
- There were dead flies and woodlouse collected on windowsills and the floor of the conservatory. We also saw excessive numbers of live woodlouse in people's bedrooms.
- There were damp and mouldy areas in the service and wallpaper peeling away as a result. We also saw this in one person's bedroom.
- Carpets were dirty in the communal areas and in people's bedrooms.
- The service smelt malodorous in corridors by people's bedrooms. We saw stained bedsheets which had not been changed even though beds had been made. We also saw stained pillows that remained in use.
- Furniture in people's bedrooms and in the lounge were stained and some coverings had been compromised so were an infection control risk.
- In the kitchen there were large cobwebs in the windows, dusty window sills and dirty edging around the worktop. Open cupboards containing cooking pots and pans were at floor level. The finish on cupboards had cracks making them difficult to keep clean. The floors had thick accumulations of dirt all around the edges. The lead from a hot water boiler was thick with grease and dirt.
- In the laundry, dirty mop heads and painting equipment were in the sink and on the drainer. The sink was covered in paint splashes. Clean clothes and other equipment which should have been stored elsewhere to prevent cross-contamination, were stored in the laundry. The floor around the washing machine was dirty.
- Jugs of drink in people's rooms and in communal areas were not covered.
- All of these incidences increased the risk of cross contamination and infection.

The provider was not managing and mitigating risks of infection to people effectively. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

- There was a failure to safeguard people. Incidents of unexplained bruising to people had not been reported as required to the local safeguarding authority in line with legislation.
- The provider failed to assure us that they had systems in place for reporting safeguarding incidents because they did not supply their safeguarding policy when requested during and post inspection.
- We looked at the staff training matrixes provided post inspection these did not demonstrate that whistleblowing training was available to staff. In addition, some staff had not undertaken safeguarding training as required .

The failure to safeguard people by not having systems in place to report potential abuse, amounted to 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.

Recruitment

● A member of staff recruited since the last inspection had not been recruited safely. An enhanced Disclosure and Barring Service (DBS) check had not been completed before they had started work. DBS checks ensure that people barred from working with certain groups such as vulnerable adults would be identified. We found that a new employee had been shadowing staff and had been rostered to work alone without having a DBS check completed.

The failure to ensure there were robust recruitment procedures amounted to a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● People were at risk of avoidable harm. There was no analysis of incidents and accidents and oversight of falls in place to fully identify potential causes or triggers for incidents. By not thoroughly analysing these incidents the provider had not ensured appropriate measures were in place to reduce the associated risks to prevent recurrence.

Requires Improvement

Is the service effective?

Our findings

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

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.

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.

● Consent to care was not always sought in line with guidance and legislation. There were no mental capacity assessments and best interest decisions in relation to bed rails and sensor mats. Staff had recorded that people's relatives, and district nurses had consented however there was nothing to show how the decision had been reached or whether people had been consulted. Additionally, there was nothing written to show less restrictive options had been considered.
● Some people had gates in their bedroom doorways. Staff said this was to prevent other residents walking into people's bedrooms. There was limited information in place to show whether each person had been consulted in this decision, or whether less restrictive options had been considered.

The failure to ensure that peoples' rights were upheld in line with Mental Capacity Act legislation was a breach of Regulation 11 (Consent) of the Care Quality Commission (Registration) Regulations 2009

● Where restrictions had been placed on people's liberty to keep them safe, DoLS authorisation had been applied for and granted for some people.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not receive nutritious food adequate to sustain good health. The majority of meals provided

were frozen with little or no vegetable or fruit accompaniments. We looked in the fridges, freezers and cupboards and found little food. People had on occasion been given boiled noodles on toast for their evening meal and cornflakes for dessert. Evening meals consisted of either sandwiches or something on toast. Records showed that people regularly asked for fish which wasn't provided.
● People who received pureed food did not receive the separate parts of their meal as separate puree, shaped to imitate the food that had been pureed. All parts of the meal were pureed together; the end result did not resemble an appetising meal for people. People would be unable to taste each part of their meal individually.

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

● People had access to drinks throughout the day and we saw that people who stayed in their bedrooms had a drink close by.

Staff support: induction, training, skills and experience
● The provider supplied the training matrix to us post inspection. We were not assured that staff had the relevant training to meet people's specific needs. There was no training recorded in relation to skin integrity, continence management and end of life care.
● We reviewed the supervision records of three staff and found that two staff had received supervision in a combination of ways through spot checks and one to one meetings. The other staff member did not have any supervision record despite having worked in the service for some time.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Oral health care plans did not provide detailed guidance for staff about people's oral health care and when people should be referred to their dentist.
● People's weights were monitored monthly. Staff told us nobody was having their food and fluid intake monitored; although in one of the plans we looked at staff had written the person was being monitored.
● People had access to ongoing healthcare. Records showed people had been reviewed by the GP, CPN and district nurses.

Adapting service, design, decoration to meet people's needs
● We were told that the conservatory was used as a dining room, however during the inspection people ate at little side tables which were not at the right height or position for dining. The staff told us that the conservatory was too cold for dining in the winter and too hot in the summer and was therefore rarely used. In addition, anyone using a wheelchair would be unable to enter the conservatory without assistance due to the raised floor edging; a relative told us that this had prevented a person from using the conservatory.
●The decoration within the service had not been adapted to meet people's needs. There were few adaptations to support people living with sensory impairment or dementia to navigate around the home.
● Some people's bedrooms were personalised and contained things important to them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care assessments identified some people's needs however they had not been updated to reflect people's current needs. This meant that staff did not have full information on how best to meet these needs and people's choices in line with best practice guidance. Staff did not have the guidance to ensure the care they provided was appropriate and person-centred care.

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 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 treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- People's dignity and independence was not respected. People were seen to be unkempt with food and stains on their clothing throughout the inspection. Staff did not help people remove the stains or to change into clean clothes. People smelt malodorous and some had dirty faces.
- People's autonomy was not supported around their choices of care. People and relatives told us that the service did not support people to bath or shower as regularly as they would like.
- People were not always well treated in respect of their social and emotional needs due to a lack of staff. There was very little interaction between people and staff. Staff did not sit and talk with people for a meaningful length of time as they were task orientated. For example, people who could not leave their rooms did not have any companionship to ensure their needs were met. We saw people looking for staff support during the inspection.
- There were long periods during the inspection when no staff were visible throughout the building. Even when staff were not providing care, they did not sit with people or stop and talk with them, other than, "I'll try and fix the telly," and "Alright love?" Staff tended to sit in the office away from people. We observed no open and affectionate relationships between staff and people.
- People were not always respected by staff. We saw a staff member assisting someone to eat who was sat up in bed. The staff member had put on the person's radio; the radio was on loudly enough to be heard in the outside corridor. The radio channel was playing modern 'pop' chart music. We asked the staff member if the music was the person's choice; the staff member said they just put the radio on and didn't know. We noted the person's TV was also on and had been on previous to the person being assisted to eat. The radio had been put on for the staff member's benefit and not for the person.
- During the morning of the inspection the TV in the communal lounge stopped working, whilst waiting for the TV to come back on a staff member stood in the lounge looking around the room but not attempting to speak to any of the people there, some of whom were visibly annoyed at the TV going off. One person said, "I may as well sleep that's all I ever do."
- People were not involved in reviews of their care plans; the provider missed this opportunity to find out what people required of their care and support.

The failure to preserve the respect and dignity of people by supporting their autonomy, independence and

involvement in the service was a breach of Regulation 10 (Dignity and respect) of the Care Quality Commission (Registration) Regulations 2009.

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; End of life care and support

●People were not involved in developing their care plan and individual needs were not taken into account.
● Monthly care reviews had been documented however there was no evidence that people and/or their relatives were invited to participate in this process. We noted that no reviews had taken place since January 2020.
● Care plans had significant amounts of information missing. For example, people who had been identified as a high risk of choking, did not have a prevention of choking plan in place. One person who staff said and we observed was bed bound did not have a skin integrity plan in place.
● There was a lack of adequate end of life care planning including for two people who were identified as needing end of life care. There were no end of life care plans in place to guide staff about how to meet their specific needs and pain management.
● Care plans did not inform staff of people's choices and preferences for a male or female member of staff to support them. We were made aware that people had specified their preference, and this had not been met and recorded. We saw a complaint made with regards a person receiving care from an opposite gender care staff member when they had specified this did not happen.
● People's choices about clothes they liked to wear had not been documented consistently. There was no information in the plans on how to maintain people's dignity, other than statements such as, 'Staff remind [them] if [they] appears confused of what the procedure is to complete personal care and maintain [their] dignity.'
● Daily care logs were not consistently completed; there were gaps noted in several logs. Care logs did not show that people had their continence needs met because staff had not documented when continence aids had been changed.
● Although plans noted that people were at risk of social isolation, it was not clear how the service reduced this risk. Activity care plans had limited information . For example, one person's plan stated their preference for not participating; the plan read, "I don't like to leave my room and socialise with others, but I don't mind having chats with the staff when they pop in to see me. I like my bedroom door open so I can see what's going on. "Staff have offered me to have my own TV on or to listen to music but as I can't hear or see very well it's not something I want to do anymore." This person had one activity logged which read, 'Staff went in and had a little chat.' It was unclear how a 'little chat' was considered to be an activity. Other activity records were in place, however one person's records had not been filled in after 26 January 2020. The same person's record showed three activities logged for the whole of January. People had not had activities recorded for

six weeks previous to the inspection.

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.
● There was a risk that people's communication needs might not be met because there were no communication plans in place. In one person's plan, it was noted they were at risk of self-neglect. The guidance for staff was limited to, "Unable to reliably communicate or make needs known. Is reliant on others to maintain, promote and achieve all activities of daily living on [their] behalf." There was nothing documented to inform staff how the person communicated, how they would know what the person wanted in order to meet their needs, or how the person might show they were in pain.

The failure to ensure people received person centred care was a breach of Regulation 9 (Person centred care) of the Care Quality Commission (Registration) Regulations 2009

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
● There were no activities taking place. The staff told us they were waiting for an activities coordinator to be employed. The activities planner showed that activities would take place on Mondays, Wednesdays and Fridays , there was nothing planned for the weekend or for people who were unable to leave their room. Activities records identified that activities had not been taking place; this was confirmed by staff.
● People who did not leave their room very often had no companionship other than when relatives visited. Their need for company was not being met. There were no records to show how the provider ensured activities for people who did not access group activities when they were available.
● People who required staff support to leave the service did not have regular access to the local community. People who went out regularly, were taken by their relatives or care provided from outside of the service. One person who had lived at the service for over three years had never been out with staff despite wanting to go out shopping.

The failure to ensure people received support to access activities was a breach of Regulation 9 (Person centred care) of the Care Quality Commission (Registration) Regulations 2009

Improving care quality in response to complaints or concerns
● Where the service had received a complaint, this had been investigated and responded to.

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 requires improvement. 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

- The provider had consistently failed to sustain improvement in the service over a number of years.
- The provider's governance system was not robust enough to ensure that they identified shortfalls in the service and rectified them in a timely way.
- The provider has not used feedback to improve the quality of the service. The home has consistently been rated requires improvement at the last seven ratings inspections since 2014. Some of the regulatory breaches have been repeated.
- There was no managerial oversight of the service; the most recent manager was no longer working at the service and their responsibilities had not been allocated to anyone else to complete. Care staff were regularly left without any on site leadership. A deputy manager had recently been appointed but they had not yet had the time to transition into the role.
- We identified serious failings in relation to the safety, quality and standard of the service. These had not been identified by the provider through their governance systems and rectified as required. Some audits were a tick box form and any actions identified did not have a clear action plan with the person responsible and checks on whether actions had been completed.
- The provider's quality assurance systems had failed to ensure that records such as the recording of meals, continence changes and repositioning were made. Records in relation to people's needs were not completed as required.
- The service environment was unclean. The provider had visited the service a day or so before the inspection. The provider informed us after the inspection, they accepted the service environment was not as clean as it could have been.
- Actions in relation to a fire risk assessment undertaken in June 2019 had not been completed even after review by the provider.
- People's care plans had not been reviewed effectively to ensure risks to people's health and welfare were mitigated.
- Activities were not effectively monitored by the provider for their suitability or for their provision, particularly for people who did not access group activities.
- Medicine audits failed to identify shortfalls found at this inspection.
- The provider audit process did not include a system to identify people who did not have appropriate best

interest decisions in place.
● Statutory notifications had not been made in line with current legislation to allow the Care Quality Commission to monitor the service. All services registered with the Commission must notify us about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The provider's governance system had not identified statutory notifications had not been made as required.

The failure to ensure the quality of service provision through effective governance was a breach of Regulation 17 (Good governance) of the Care Quality Commission (Registration) Regulations 2009

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
● People were not engaged in creating strong links with the local community as they did not have the relevant staff support.
● The provider failed to provide relevant policies to us after the inspection and we were therefore unable to check how the provider ensured the service achieved good outcomes for people and created.

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
● We were not assured that the provider had acted in line with the duty of candour due to the number of safeguarding events that had that had not been notified to us, and the provider's failure to provide requested information post inspection.

Continuous learning and improving care
● We asked the provider to supply the staff training matrix to us post inspection. The copies of the matrix supplied demonstrated that staff had not completed training that had been required since at least December 2019. Therefore, we cannot be assured that continuous learning to improve care was taking place.

Working in partnership with others
● The service worked in partnership with the local district nursing team, however it was clear from records that the staff did not always follow the guidance provided.
● There was no registered manager available to attend local forums or other stakeholder and partnership events.

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 had not received person centred care. People had not received support to access activities.

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 preserve the respect and dignity of people by supporting their autonomy, independence and involvement in the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to ensure that peoples' rights were upheld in line with Mental Capacity Act legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not safe because the provider was not managing and mitigating risks to people effectively, including those relating to medicine management. The provider was not managing and mitigating

risks of infection to people effectively

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 There was a failure to safeguard people by not reporting potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the quality of service provision through effective governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure there were robust recruitment procedures

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet peoples needs