RCH Care Homes Limited

Park View Care Centre

Inspection report

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Date of inspection visit:
30 May 2023
31 May 2023
06 June 2023
14 June 2023

Date of publication:
14 November 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Park View Care Centre is a residential care home providing personal and nursing care to up to 88 people. The home provides support to people aged 18 and over, some of whom live with dementia or require complex nursing care. At the time of our inspection there were 85 people living in the home.

People's experience of using this service and what we found
People told us they were not receiving person-centred care that promoted their choice, needs or independence. People were placed at serious risk of harm because care was not delivered safely. Risks people faced were not fully identified, assessed, or reviewed. Staff were not always following people's care plans or risk assessments which put people at risk of avoidable harm. Medicines were not always managed safely and provided to people as prescribed.

People were not supported to maintain a balanced diet and meal options did not reflect people's individual needs and choices. Staff did not always follow each person's dietary requirement or support needs, which placed them at serious risk of choking, malnutrition, and dehydration. People had their weights monitored but these were not always regular enough to mitigate the risk of malnutrition.

People and their relatives were not involved in decisions about their care or care reviews. People were not always treated with dignity and respect and their independence was not promoted. A relative told us, "There's lot of confused people there and staff don't know how to deal with it. They just ignore it." People had to wait for extended periods of time to receive support. There was not enough staff to meet people's physical and emotional needs. A relative told us about their observations, "On the ground floor at weekends I have to search and find a nurse. Staff ignore people who are shouting "help me, help me". Bells go off and they ignore it."

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 and their relatives told us their complaints were not always listened to and addressed appropriately. Relatives told us, "I've complained, and they haven't acted on it. It was a few months ago and I've heard nothing back."

The provider failed to ensure the quality and safety of the service was monitored effectively. The provider's quality assurance systems were not effective. Records at the service, including people's care records, were not always present, accurate or reviewed when required. This put people at risk of not receiving the care they needed safely and consistently and staff not knowing how to support them when their needs had changed.

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 requires improvement (published 19 May 2022) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the provider considered a formal audit of call bell response times. At this inspection we found the provider had not made improvements in reviewing the staffing levels to ensure people received support as per their individual needs and in a timely way.

Why we inspected
The inspection was prompted in part due to concerns received about the safety of care provided. A decision was made for us to inspect and examine those risks.

The inspection was also prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home 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.

You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

The provider put an action plan in place to address the breaches identified during this inspection.

Enforcement
At this inspection we have identified breaches in relation to management of risk, safeguarding, staffing and staff training, person-centred care, respect and dignity, provider oversight and failure to learn from accidents, incidents and complaints.

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

On 21 June 2023, we imposed urgent conditions on the provider's registration to ensure that risks relating to choking, malnutrition and dehydration were safely managed. We also requested the provider reviewed their quality assurance systems to ensure effective oversight of these risks, and that the relevant investigations were completed. We requested the service provided regular updates to CQC. We also restricted any new admissions to the service.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always effective.

Details are in our effective findings below.

Requires Improvement

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

Park View Care Centre

Detailed findings

Background to this 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
The inspection was undertaken by 2 inspectors and 2 Experts by Experience. 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
Park View Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Park View Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service including information submitted to CQC by the provider about specific incidents. We sought feedback from the local authority and reviewed the information they provided. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We carried out observations in the communal areas of the service. We spoke with 20 people living at the service and 23 relatives about their experience of the care provided. We spoke with 6 professionals and 11 members of staff. This included the registered manager, the deputy manager, the operations and quality managers, 3 clinical staff, 2 care staff, the chef and the receptionist. We reviewed a range of records. This included 22 people's care records, medicines records for 18 people and recruitment records for 5 members of staff. A variety of records relating to the management of the service, including audits, checks, policies and procedures were also reviewed.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People were at risk of potential harm as risks were not fully assessed, reviewed or mitigated. People who were at risk of choking did not always have appropriate care plans and risk assessments in place. Lack of guidance for staff on how to support people safely put them at risk of choking.
- People who were assessed as being at risk of choking and had special diets in place to mitigate that risk, continued to be placed at risk. People were not always supported by staff to sit in an upright position whilst eating, which placed them at risk of choking. People's care records confirmed they were not always provided with suitable and safe food consistencies they were assessed as requiring. For example, one person's records showed staff served them food modified to an incorrect consistency on 3 separate occasions.
- Staff were not always following people's speech and language therapy (SALT) guidance. For example, 2 people had SALT guidance in place stating they required support to eat and drink. Guidance for staff for one person detailed that they must be in a safe and upright position and staff support was required to reduce their risk of choking. We observed staff not following this guidance. For another person they were provided with their drink without a straw which they required to drink safely.
- People did not always have appropriate risk assessments in place. For example, one person told us how they had a choking incident and staff had to provide them with emergency first aid at the time. No incident report or risk assessment was completed following this incident until it was completed during the inspection. Staff continued to provide the person with a normal diet and tablet medicines. People who were at risk of choking did not always have appropriate care plans and risk assessments in place. Lack of guidance for staff on how to support people safely put them at risk of choking.
- People were not always protected from the risk of malnutrition. Risks to people had not been mitigated despite same concerns being raised with the provider during the last inspection of this service. One person told us, "I can't cope with eating a lot. [Staff] don't help me with eating. I don't eat [the meal] because I know I can't handle it." This person's records showed they had refused their lunchtime meal for 7 days. Staff supporting this person were unaware of this and the person told us they were worried to eat as they had also choked previously. We fed this back to the provider who took action to address this and support the

person.
● Where people's food intake was assessed as needing monitoring, records did not detail what was offered, how staff supported people, when they refused meals or how much people ate. One person's weight was not checked for several weeks despite records showing them losing weight in April 2023 and being assessed as requiring weekly weight checks to monitor risks.
● We observed a staff member offering a meal to a person who refused it. When asked, staff did not know if they would retry to encourage person to eat. They said they would record their refusal. Two relatives told us people were at risk of missing their meals if they did not visit to support them as staff lacked understanding how to support their loved ones to eat.
● People were not supported safely around the risk of dehydration. Fluid intake charts for 3 people showed they were not drinking enough as per their care plans. Care plans did not provide accurate guidance on how much people should drink. We saw one person was given a thickened drink and not offered any support to drink it on the day of the inspection. Their records showed between May and June 2023 they drank substantially below their assessed need, more than three times less than assessed as needed per day. This put people at risk of dehydration.

People were at serious risk of harm as risks associated with choking, malnutrition and dehydration had not been fully assessed, mitigated or monitored. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider created an action plan detailing how they will address the shortfalls identified.
● The provider completed health and safety, fire safety and environmental checks as required.

Using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People did not receive their medicines safely. People did not always receive their medicines as prescribed. One person told us, "Sometimes (I don't receive nutritional supplement), not even once a day." This person had oral nutritional supplements prescribed 3 times a day, but their care records showed they had not received them as prescribed for most of May 2023. There were 8 days when they had not received any supplements at all. This put them at risk of further weight loss and malnutrition.
● Serious medication errors were not always identified by staff. For example, a medicine which should not be crushed, as per manufacturer's instructions, was crushed, and given in an unsafe way. This was not identified by staff for 5 days despite clear instructions on the medicines administration chart (MAR).
● Not all medicines administration records were completed fully and safely. There was a lack of guidance around when to administer 'when required' medicines for 4 people. This was, for example, to mitigate the risk of constipation, in emergencies or to help them manage their distress. One person received medicine which was supporting them with distressed behaviour on 3 occasions without staff recording what this behaviour was and what less restrictive support they tried to offer prior to administering medicines. This practice was not in line with national best practice guidance around supporting people in least restrictive ways and put people at risk of not receiving the medicines when needed or being over-medicated.

Staff failed to manage medicines safely which put people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● The provider did not always act to appropriately investigate, and address lessons learnt form accidents and incidents which put people at risk of avoidable harm and potential abuse. People's feedback and records showed incidents were not always thoroughly investigated and learnt from. One relative said, "I can't remember the last time [person] had a bath or a shower. I don't think [person] is always safe because they had quite a few bruises. They don't tell me if anything happens. When my [relative] went in last, they said, '[person] has got a lovely black eye.' I don't know what's going on." We reported these concerns to the Local Authority for consideration under their safeguarding policy.

● Investigations were not always completed into incidents. For example, a complaint had been made. We discussed the complaint with the registered manager who was dismissive. The allegation had not been investigated despite the concerns mirroring previous allegations made by people and relatives regarding poor manual handling practices.

● People were not effectively protected from abuse and neglect. People and their relatives told us their concerns were not always listened to or acted on to protect them. One person told us they repeatedly complained about one staff's way of treating them but were not listened to by other staff and stated that nothing was done. They also commented, "Good method of getting attention is banging the cup on the floor. It's like a prison." The management told us those concerns were around a staff member who no longer worked in the service but there was no assurance what had been done about the allegations at the time they had been raised.

● The local authority safeguarding team told us that they were not confident in the service's response to safeguarding concerns that had been raised and felt that people continued to be at risk living at the service. For example, there was no follow up actions recorded and no further lessons learnt were identified despite repeated unwitnessed falls and people found with bruising or incidents of distressed behaviours. The provider had failed to effectively address the concerns we raised at the last inspection around management of dehydration or malnutrition risks.

People were not protected from the risk of abuse and neglect. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection we recommended the provider considered a formal audit of call bell response times. The provider had not made improvements in reviewing the staffing levels to ensure people received support as per their individual needs and in a timely way.

● There were not enough staff to provide people with timely and safe care. Some relatives told us staffing was an issue which impacted on people being able to receive care when needed.

● During the inspection we observed that people had to wait for extended periods of time or shout out to receive support from staff. One person told us they had been put off from going to the lounge because they had to wait so long to be taken back to their room after lunch, that they had incontinence accidents which left them very uncomfortable and with no support.

● Staffing levels did not allow for people to spend time outside of their rooms. We were told one person could not spend their time in the communal areas because they would require one to one support from staff and this was not possible. As a result, the person sat in isolation and unstimulated in their room. One relative commented, "[Staff] could have a chat (with person). He is lonely, but [staff] don't have the time."

● The provider had a system in place of establishing staffing levels in relation to people's care. However, this was not effective in identifying people's actual level of need and ensuring ensure staff provided safe and quality support at all times.

There were not enough staff to support people safely. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been recruited safely. New staff members had to provide professional references, proof of ID and right to work in UK and were interviewed by the management. Staff completed Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some improvements had been made and the provider was no longer in breach of regulation around infection prevention and control, there were further areas that still required improvement.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was generally clean and hygienic. However, people's relatives told us they sometimes found their loved ones in soaked beds and the cleanliness of the service could be improved. During the inspection, we observed some areas of the service were unclean, including people's bedding or bedroom walls being stained. We have signposted the provider to resources to develop their approach.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.
● People could receive visitors when they wished to do so and there were no restrictions in place on visiting. A relative confirmed this and told us, "I can go and visit anytime.

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 our last comprehensive inspection in March 2020, we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs and choices were not appropriately assessed in line with best practice guidance, standards and the law. Holistic assessments of people's needs were not completed and care plans in place did not include individual's needs and choices. Records did not show people were asked for their choices around the support they received. People told us that they had not been consulted about their care plan or wants and wishes.
- People were not always supported appropriately when their needs were changing. The provider did not use any nationally recognised tools, for example National Early Warning Score (NEWS) scoring to recognise when people were deteriorating. Not all people who could experience distress had appropriate robust behavioural plans in place to ensure they were supported in a positive and least restrictive way when they became distressed.
- Staff did not support people with their oral care as per national best practice guidance. Oral health assessments took place, but staff did not follow the care plan guidance. One person was assessed as requiring full assistance with their oral care. The person told us they had no support from staff with this. Their care records showed they were supported with mouth care on 7 mornings over a 28-day period.

The provider had failed to do everything reasonably practicable to make sure that people who use the service received person-centred care and treatment that was appropriate, met their needs and reflected their personal preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not always have appropriate skills and experience for their roles. People and their relatives told us they had limited trust in staff skills. One person said, "[Staff] have no idea how to use the [care equipment]."
- Staff did not always complete the required for their roles training. For example, not all staff completed their manual handling training or oral care training. There was no training on offer around supporting people at the end stages of their lives despite the service providing this type of care. People's records confirmed staff did not always provide appropriate oral care to people. Staff had not always appropriately identified when people were reaching end of life care stage, despite the management stating their deaths were expected outcomes of their health conditions. The lack of staff skills to recognise and meet people's needs put people at risk of receiving substandard care.

Staff did not always have the right skills, knowledge and experience to support people safely. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 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, 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 follow MCA when supporting people.
● Where people were found to lack capacity, the service did not always follow appropriate best interests decision making processes and there were no records of how they involved people's representatives. A relative said, "I'm not involved at all by the home."
●One person's bedroom was stripped of nearly all furniture and decorations without discussing the reasons and least restrictive options with this person's representatives or relevant care documentation in place. There was lack of recorded information around what changes in this person's needs and particular circumstances led staff to make a decision on their behalf and restrict their immediate living environment.

The provider failed to ensure they obtained consent of relevant person to provide care and treatment and that they followed MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 effectively supported to access other healthcare services and their changing needs and risks have not always been recognised. One relative told us, "He's been referred to the dentist but is reluctant to go there. He won't brush his teeth and has lost one tooth and will soon loose other rotten ones."
● Although people were referred to other healthcare professionals, those referrals were not always timely or followed up when needed. For example, there was a lack of evidence of people being referred to dietician, physiotherapy, occupational therapy or mental health services in a timely way.
● People were supported to see their GP when needed and the GP visited the service weekly. One relative told us, "The doctor goes in regularly, and they take him to the hospital regularly to make [health] checks. [Staff] always keep me informed."

Supporting people to eat and drink enough to maintain a balanced diet
● People did not always receive effective support to eat and drink well. People and relatives' feedback about the quality of meals on offer was mixed but both expressed concerns around support with eating and drinking. One person told us, "I have not eaten today. [Staff] gave me my breakfast when I was asleep, so

when I woke up it was stone cold." A relative told us, " No one is encouraging her to eat. The staff is not there to sit down with her and encourage her to it."

● We observed people were not always supported to eat or drink when they needed to be. People were not encouraged and supported to eat in the dining room with others to enhance their experience of meals. We have fed this back to staff and some people were supported to eat at a table rather than in bed.

● The provider took action based on our feedback and started addressing the shortfalls in their catering offer during the inspection and as a part of the wider action plan for the service. We saw some improvements, around information available to the chef had been made after the first day of the inspection. Following the inspection, the provider employed a new chef who arranged additional staff training, including dietetic training. We will follow this up at the next inspection.

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

● Although there were some adaptations in place, such as assisted bathrooms, these were not used effectively to provide people with person-centred care. Some bathrooms were cluttered and used a storage.

● People's bedrooms were not always personalised and fit for their needs. For example, there was little to provide people with things to do or enjoy during the day and most people remained in their bedrooms. One relative told us, "The place is not very dementia friendly." Another relative commented, "The room is clean, and the environment is very good. There are flowers in the foyer".

● Not everyone had call bells within reach, those who were deemed unsafe to use a call bell did not have an alternative and relatives felt they were not checked regularly, as stated in their care plans. A relative told us, "Staff ignore people who are shouting 'help me. help me'. Bells go off and they ignore it. [My loved one] can't use the buzzer. Staff should be checking her hourly to see they are comfortable. But they don't."

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 our last comprehensive inspection in March 2020, we rated this key question good. At this inspection the rating has changed 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; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Staff did not always respond when people were in discomfort or distress. We had to intervene and ask staff to support someone who was distressed and needed obvious support. This was despite there being 5 or 6 care staff in the vicinity.
- People and their representatives told us they were not routinely involved in their care and enabled to express their views and wishes. One relative said, "I feel we are not kept 100% up to speed about her decline." Although some relatives were involved in their loved care plans, most people and their family members told us they were not asked for their views. People's records lacked evidence on how people and their representatives were involved in decisions around their care.
- People's dignity was not always respected by staff. One relative told us their loved one had an incontinence accident as they were not listened to when they told staff they did not wish to be supported to go to the toilet by a male carer.
- People were not always supported to maintain their independence. One person told us, "I do not want to worry about losing the use of my legs. I just want to be able to do things for myself. I have been out of bed twice. [Staff] won't even let me stand up."

Staff did not always treat people with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some relatives were complimentary about staff and the way their loved ones were supported. They commented some carers were kind and compassionate and treated people well.
- People's relatives told us staff respected people's privacy when providing care. One relative said, "[Staff] always shut the door and I'm told to be out of the room."
- Relatives were invited to provide feedback on the service their loved ones received at relatives' meetings. Records of these contained positive comments.

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 good. At this inspection the rating has changed 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; 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

- Care was not always personalised and planned to meet people's needs and preferences. People were not always supported to follow their interests or participate in activities relevant to them. People and their relatives told us care was not always person-centred and did not fully meet their needs and wishes. People's care plans did not always clearly describe their preferences, best interests decisions made around their care did not involve the person or those appointed to legally represent them.
- People and their relatives described the care provided by staff as task-centred rather than person-centred. We observed people spent most of their time without stimulation, social and emotional support, despite some activities being on offer in the service. One person told us, "I don't see anyone. No one comes and talks to me. I do not get out of bed."
- People's relatives told us they were worried about their loved ones becoming socially isolated and the impact it had on their wellbeing. A relative said, "Yes, she is safe but lonely. She's sitting up in her wheelchair but getting no conversation. No sociality at all."
- Relatives told us people were not offered to go into the communal areas or outside but were left lying in bed all day. A relative commented, "There are activities but only on the ground floor. Most people are left alone and abandoned." They told us there were no activities which would suit their family member, and no one visited them. This put people at risk of social isolation and not receiving person-centred care which affected their wellbeing.

The provider did not take all reasonable steps to ensure people received person-centred care meeting their social and emotional needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- People did not always receive compassionate and good quality care at the end stages of their lives. People were not always given the opportunity to die in a dignified manner. One person's records showed they were given a tablet medicine which they could not swallow in the 2 days prior to their death, despite them only being prescribed liquid medication.
- Relatives had raised complaints about the standard of care provided to their loved one at the end of their life. The local authority raised their concerns around poor oral care with us after visiting an end-of-life resident, whose mouth and tongue were dry.

The provider did not take all reasonable steps to ensure people received person-centred care meeting their

needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Complaints were not acted upon to continually improve the service and people's experience of care. One relative who made formal complaint told us they were not contacted by the service to offer any resolutions to their concerns. They commented, "[Management] just ignore me. [The registered manager] is not interested in what I want."

● People and their relatives knew how to complain but told us they lacked confidence the management would act on their complaints. One relative told us, "We have not raised any concerns. Nothing would be done anyway. We asked a number of times for [person's] nails to be clipped and it wasn't done."

● Other relatives we spoke with also complained to the service and have not heard back about what was done in relation to their concerns. One of them said, "They don't take things seriously."

● The provider's complaints records did not fully reflect the feedback we received around the number of complaints made to the service. There was a lack of robust systems in place to record, investigate and respond to concerns fully. People were put at risk as the provider did not address complaints effectively to drive improvements in the service and to minimise risks to people.

The provider had failed to appropriately investigate and learn from complaints. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The service has not always taken steps to comply with the Accessible Information Standards. People's communication needs were not always assessed and not all care plans provided the full information for staff to follow to effectively communicate with people. For example, one person's records showed they had limited verbal communication. The guidance for staff was to monitor facial expressions and body language. There was no person-centred information about what a particular expression or certain body language may mean the person was experiencing or how they may be feeling.

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 requires improvement. At this inspection the rating has changed 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service; and mitigate the risks relating to the health, safety and welfare of people. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Managers and staff were not clear on their roles and responsibilities. Systems were not in place to continually learn and improve people's experiences of care. The provider failed to maintain effective oversight of the service and have good governance systems in place. During the inspection we identified serious concerns in relation to risk management, medicines management, lack of people involvement in their care, care plan reviews, record keeping, staff training and learning from incidents and accidents. These shortfalls affecting safety and quality of people's care had not been identified by the registered manager or the provider. There was no evidence the provider had reviewed actions taken and learnt lessons following incidents and accidents.
● People's records were not always detailed enough or up to date which put them at risk of not receiving safe consistent care. The provider had not identified issues around people's care records in relation to their choking risk, nutrition or hydration needs, support required expressing emotions of distress. The provider's governance systems did not highlight concerns relating to people's dignity and rights. Information in people's care documentation was contradictory, incomplete, and inaccurate. This put people at risk of avoidable harm, both physically and emotionally.
● The registered manager was unable to provide evidence requested by the inspection team. On the first day of the inspection, we raised with the management that 1 person did not have an appropriate risk management plan despite them being at significant risk of choking. Despite that, no action had been taken by the third day of the inspection and reporting of the previous choking incident identified had not been completed.
● The provider did not ensure their own policies and procedures were followed by staff. For example, reporting and investigating incidents and accidents. The service was in breach of multiple regulations for the third consecutive inspection. The provider failed to address shortfalls and ensure people's care was provided in line with regulatory requirements.

The provider had failed to operate effective governance and quality monitoring systems to ensure people receive safe and good quality care. The provider had failed to assess, monitor, and improve the quality and safety of the service; and mitigate the risks relating to the health, safety, and welfare of people. The provider had failed to maintain securely an accurate, complete, and contemporaneous record in respect of each person receiving care. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider shared an action plan with CQC following the inspection explaining how they would improve the service and people's experience of care. Following the inspection, the provider engaged a consultant and a new manager to drive improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 culture of the service was not person-centred and inclusive. Most of the people we spoke with, and their relatives did not feel the care they were provided was consistently achieving positive outcomes for them. People's relatives told us management were not always approachable and welcoming. A relative said, "The manager will walk past and won't even say 'hello.' The management isn't the greatest."
● People and their relatives told us they did not find it easy to speak up and did not feel listened to when they did." People's relatives told us it was not easy to contact the service and phones were not always answered. Some relatives commented they did not know who the registered manager was or chose not to speak with them as they did not like how they were treated. One relative said, "[Staff and the management] don't seem to listen. I can moan but they don't take things seriously. The place and service are badly managed."
● The registered manager and provider had not always been open and honest with people when things had gone wrong. Records showed investigations were not always completed when incidents occurred, and people were not informed when required. Some responses to incidents and complaints were using defensive language and offered no apologies to affected people when shortfalls had been identified.

The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Some relatives gave more positive feedback. They told us staff listened to them, the registered manager was approachable, and they could speak with them. They found the communication with the service to be good and staff to act on their feedback.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People, their relatives and staff were not always engaged and involved in the service. Staff and management did not always work in partnership with others.
● People and their representatives had some opportunities to share their views but there was limited assurance the provider was improving the service based on people's feedback. People told us they had completed a survey prior to our inspection but had not had any feedback yet. Meetings were held for relatives, but relatives did not know of the outcomes of those meetings and records of discussions were not shared with them.
● Relatives overall felt the communication with the service needed to be improved. They were not always

informed about important changes in their loved one's needs or incidents and accidents. One relative said, "Staff don't inform me. I have to ask."

● The service did not have clear leadership to empower staff or people to achieve positive good outcomes.

● Staff did not always work in partnership with others in an effective way. Referrals to other healthcare services were not always submitted or were delayed. A visiting professional had to ask staff to refer a person to SALT as they noticed they were having trouble swallowing, yet this action had not been taken by the service. When professionals gave guidance to staff, this was not always followed, for example around fluid intake monitoring charts or specific dietary guidance.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not take all reasonable steps to ensure people received person-centred care meeting their social and emotional needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider has failed to ensure that people are treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure they obtained consent of relevant person to provide care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider has failed to protect people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

Diagnostic and screening procedures Treatment of disease, disorder or injury	The provider had failed to appropriately investigate and learn from complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to protect people from the serious risk of harm from choking, malnutrition and dehydration and medicines mismanagement.

The enforcement action we took:

We imposed urgent conditions on the provider's registration to ensure that risks relating to choking, malnutrition and dehydration were safely managed. We also requested the provider reviewed their quality assurance systems to ensure effective oversight of these risks, and that the relevant investigations were completed. We requested the service provided regular updates to CQC. We also restricted any new admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each person receiving care. The provider failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services

The enforcement action we took:

We imposed urgent conditions on the provider's registration to ensure that risks relating to choking, malnutrition and dehydration were safely managed. We also requested the provider reviewed their quality assurance systems to ensure effective oversight of these risks, and that the relevant investigations were completed. We requested the service provided regular updates to CQC. We also restricted any new admissions to the service.